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ABSTRACT

This manual, designed to help Head Start health coordinators effectively utilize the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program, includes background on the development and goals of the EPSDT program and information gained during implementation of 200 EPSDT/Head Start demonstration projects. Chapter titles are: (1) Background and Historical Overview (History of Government Health Care Programs for Children, Brief Overview of EPSDT, The Head Start-EPSDT Collaboration); (2) Collaboration with State and Local Health and Welfare Agencies; (3) Collaboration with Local Providers; (4) Outreach; (5) Transportation; (6) Referral and Follow-up; (7) Record Keeping; (8) Reimbursement; (9) Model of a Small Community Head Start/EPSDT Program; and (10) Recipe Wrap-up (summary). (SB)

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Recipes for Success

HEAD START AND EPSDT

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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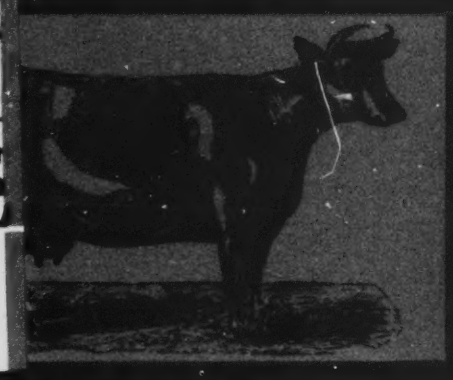

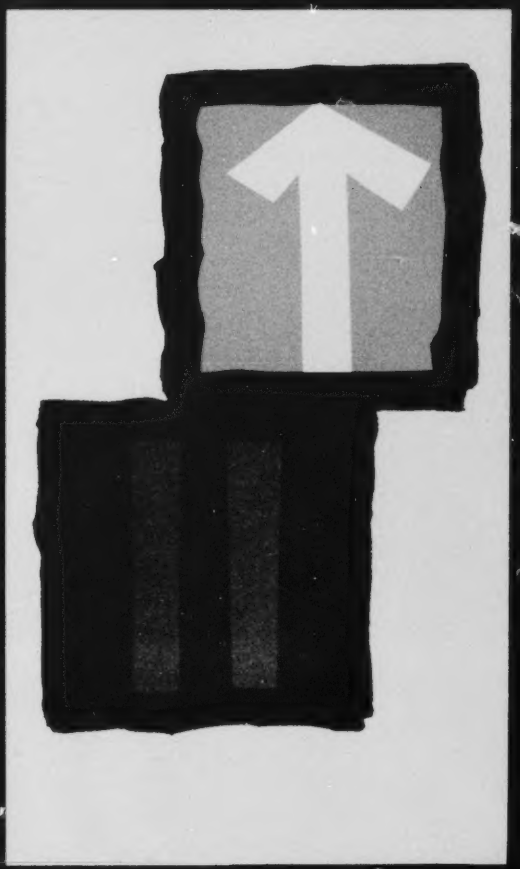

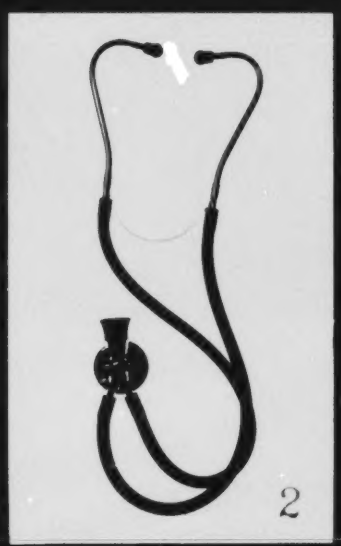

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MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

TO : Head Start Directors
Health Coordinators

DATE: August 20, 1976

FROM : John H. Meier, Ph.D.
Director, Office of Child Development
Chief, Children's Bureau

SUBJECT: Head Start and Early, Periodic Screening and Diagnosis and Treatment (EPSDT) Recipes for Success

Following is a copy of Head Start/EPSDT Recipes for Success. This manual has been developed as a result of the two year demonstration collaborative effort between Head Start and Health/Welfare agencies. The purpose of the manual is to assist Head Start programs in making maximum use of the EPSDT program.

This manual is meant to be used as a working document. It can be read in its entirety or section(s) that you feel may be most helpful to you and your program. As additional questions about the use of the EPSDT program may occur, other sections of the manual will be helpful.

At the front of the manual is a "feedback" form. After you have used the manual for approximately three months, complete the form and mail to:

Linda A. Randolph, M.D., M.P.H.
Director, Health Services
Office of Child Development
P.O. Box 1182
Washington, D.C. 20013

PS 009590

DHEW Publication No. (OHD)77-31097

CUT ALONG BROKEN LINE

FEEDBACK FORM - RECIPES FOR SUCCESS

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TITLE_____

NAME OF PROGRAM_____

ADDRESS_____

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TELEPHONE _____

(1) The most useful section(s) of the manual: _____

_____

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_____

(2) Besides myself these other persons also used the manual:

Program Director_____

Health Coordinator_____

Health Aide_____

Social Service Worker_____

Parent Council_____

Local/State EPSDT agency_____

Program Consultant_____

Health Providers_____

Others (please specify)_____

_____

(3) We would like to share other innovative approaches with Head Start Programs. Do you have any suggestions about using EPSDT in your Head Start Program which you would like to share? If so, please comment below.

HEAD START

AND

EARLY AND PERIODIC SCREENING,

DIAGNOSIS AND TREATMENT:

RECIPES FOR SUCCESS

Prepared by the Community Health Foundation,
under sub-contract to Westinghouse Health Systems
(for the Office of Child
Development - contract #S43517CHFOKHO)
Using material collected by the American
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These three organizations express their sincere appreciation to all the Health Coordinators and members of Head Start staffs who have assisted in providing resource material for Head Start and Early and Periodic Screening, Diagnosis and Treatment: Recipes for Success. We are indebted to those individuals who participated in the 200 Head Start-EPSDT demonstration programs and took time to share their experiences with us.

Recipes for Success will be distributed by the Office of Child Development to all individuals working with the health component of the Head Start Program. The manual is designed to aid them in effectively utilizing the Medicaid Early and Periodic Screening, Diagnosis and Treatment Program.

We extend special appreciation to the following Head Start programs and social service agencies for contributing materials reprinted in this manual.

Ninth District Opportunity, Inc.
Gainsville, Georgia

Bolivar County Head Start Program
Cleveland, Mississippi

West Central Missouri Rural Development Corp.
Appleton City, Missouri

State Welfare Agency
New Mexico Health and Social Services Department
Albuquerque, New Mexico

Economic Opportunity Council of Suffolk, Inc.--
Head Start
Patchoque, New York

Jackson County Child Development Centers
Medford, Oregon

Orleans County Council of Social Agencies
Newport, Vermont

Division of Physical Health
Georgia Department of Human Resources
Atlanta, Georgia

INTRODUCTION

Purpose of "Recipes"

Head Start and Early and Periodic Screening, Diagnosis and Treatment: Recipes for Success was specifically developed for individuals working with the health component of the Head Start program. The manual is designed to aid Head Start personnel in effectively utilizing the Medicaid Early and Periodic Screening, Diagnosis and Treatment Program.

Throughout the booklet the term "Head Start Health Coordinator" refers to any individual who has primary responsibility for working with EPSDT.

The purpose of the manual is twofold: 1) to provide Head Start Health Coordinators with a better understanding of the EPSDT program and how it can assist Head Start in accomplishing its program objectives and 2) to share the knowledge and learning experiences gained from the 200 EPSDT-Head Start demonstration projects.

The manual is divided into two sections. The first section provides a summary of government health care programs for children prior to the formation of EPSDT, along with a brief overview of EPSDT and the difficulties encountered in implementing this preventive health care program for children. Also included is a summary of the initial collaboration of the Head Start and EPSDT programs.

The second section of the manual contains "recipes" to help Health Coordinators implement separate components of the Head Start-EPSDT child health care program. Resource material contained in this section was primarily generated from the 200 Head Start-EPSDT demonstration programs. The "recipes" developed by the Health Coordinators from the demonstration effort consist of summaries of approaches which Health Coordinators have found useful in working together with EPSDT. The "recipes" are intended for use as models which can be adapted to fit individual Head Start program needs. The "recipes" can stimulate new ideas to assist Head Start Health Coordinators in better utilizing EPSDT services.

Why Should Head Start Participate in EPSDT?

Head Start should participate in Medicaid EPSDT because both programs share the common goals of prevention, identification and treatment of illness, and linking the child and family to an on going health care system. In addition in order to retain Head Start health dollars for those children who do not qualify for other forms of assistance, it is important for Head Start programs to use Medicaid EPSDT funds for their EPSDT eligible children. Both programs must work together. In order to establish a collaborative relationship with EPSDT, Head Start should:

(1) Work cooperatively with state and local health and welfare agencies through contracts or agreements.

(2) Ensure that services provided to Head Start-EPSDT eligible children are reimbursed by Medicaid.

(3) Identify Head Start children potentially eligible for Medicaid and assist in their enrollment.

(4) Provide Transportation when necessary.

(5) Maintain a Record Keeping system which provides for an exchange of case management information between EPSDT and Head Start.

(6) Ensure that Referral and Follow-up services are provided.

(7) Work cooperatively with local providers. When there are no providers available or if all attempts to enlist the participation of local providers have failed, the Head Start program should consider providing EPSDT services and being reimbursed for such services.

How do Head Start programs participate in these activities to make EPSDT and Head Start programs work together?

Many Head Start programs enlist Medicaid EPSDT and local community resources to assist them in carrying out some or all of the activities. Recipes for Success is intended to provide an information exchange among Health Coordinators involved in Head Start-EPSDT programs.

In order to understand some of the difficulties inherent in implementing EPSDT services, it is helpful to be familiar with the program as a whole and to understand its history. The following section provides a brief overview of the history and development of federally subsidized child health care programs, and presents a summary of events resulting in the development of EPSDT.

SECTION I.

BACKGROUND AND HISTORICAL OVERVIEW [9]

A. HISTORY OF GOVERNMENT HEALTH CARE PROGRAMS FOR CHILDREN

1921
The Sheppard-Towner Act

was the first federal program to provide care for mothers and children through grants-in-aid to the States. The purpose of the program was to "promote the welfare and the hygiene of maternity and infancy," but the program did not clarify what services were to be provided. As a result, the states developed well-child conferences to provide preventive care to limited groups of children through voluntary and public agencies.

1935
Title V of the Social Security Act

was the first program to introduce the concept of active identification of handicapped children in need of treatment as a federal policy goal. Title V established federal grants-in-aid to states to locate and provide care to crippled children. In response, states established registries of crippled children, but did not

guarantee medical treatment to them. Title V also established the Maternal and Child Health program to provide prenatal care to mothers and health care to their young children through state health departments. States established well-child conferences and supervised maternity clinics, but no attempt was made to systematically deliver services or to identify people in need of services under this act.

The Public Assistance Titles of the 1935 Social Security Act served primarily as a payment mechanism. Benefits were limited to direct cash payments to the recipient. In many cases the money paid to the welfare recipient for medical services was used to bolster welfare payments when funds were insufficient to cover food and housing costs. The money was not used for medical care until health problems became severe.

Despite the Social Security Act's limited success in providing medical services to welfare recipients, the

program highlighted the need for a payment system to encourage people to use preventive and routine medical care.

1963-1968
Title V Programs — were expanded to include federal grants for local projects:
the Maternity and Infant Care Projects in 1963;
the Children and Youth Projects in 1965; and the
dental care and intensive infant care projects in 1968.

1965
The Office of Economic Opportunity — (OEO) established Head Start Programs which provided educational programs and a supplementary health care program for pre-school children.

1965
Title XIX of the Social Security Act, Medicaid — was introduced by the Federal government to provide medical care to individuals and families receiving Federally-aided categorical public assistance and others not receiving public assistance but whose income and resources were

insufficient to meet the costs of necessary medical services.

Within federal Medicaid guidelines states could: a) determine who was eligible for medical care services; b) select the kind and amount of services for which reimbursement could be provided; c) set the standards of health care that providers must follow; and d) determine the levels for reimbursement.

Because of its federal-state nature, Medicaid radically changed the method of allocating federal money. Prior to Title XIX, federal funds for the early child health care programs were distributed directly to state and local health departments by the Children's Bureau. Many states adopted liberal eligibility requirements to expand the availability of medical care services to more people than the federal government had anticipated. Medicaid quickly overtook the Title V programs in expenditures for health care services.

Although the Medicaid program was not specifically aimed at children, it provided payment for health services to children eligible for AFDC, and to those classified by the states as "medically needy."

Medicaid established a major federal emphasis on providing payment for medical care for certain groups of the poor. Thus, the major impact of Medicaid was to provide financial support for a broad range of health services rather than provide a system for the delivery of health care.

Medicaid's failure to link the poor to the health care system has not assured an effective utilization of health services. To be fully effective, health care programs should include outreach activities, health education, needed transportation, case management and supportive services. The poor need to be helped to use the medical care system for preventive as well as treatment care.

EPSDT evolved in an attempt to provide a comprehensive range of health care services to children eligible for Aid to Families with Dependent Children (AFDC) and the supportive services to assist in the effective utilization of such care.

B. A BRIEF OVERVIEW OF EPSDT

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is designed to give states the responsibility for providing a comprehensive range of health care services including preventive health services to low-income Medicaid eligible children. The program emphasizes the importance of outreach activities and supportive services to ensure that eligible children have the opportunity to receive comprehensive health care services.

The idea of periodically screening children of low-income families first appeared in a child health care program analysis prepared by HEW in 1966. Subsequently, President Lyndon Johnson recommended expansion of programs for early diagnosis and treatment of children with handicaps in his 1967 address to Congress. The proposed legislation which was introduced to Congress on February 20, 1967, encouraged states to extend their coverage to Medicaid eligible children by providing preventive services. After modification by Congress, the proposal resulted in the EPSDT amendment to Title XIX of the Social Security Act which requires all states with Medicaid programs to assume an active role in providing screening, diagnosis and treatment services for all eligible children under age 21.

The law stipulated EPSDT was to be implemented by July 1, 1969, however implementation was delayed because

final regulations and guidelines did not appear until two and a half years later. Clarification of the administrative framework, costs, eligibility, and scope of the program postponed its implementation until July 1, 1973.

Medical Services Administration, responsible for Medicaid in Social and Rehabilitation Services, was given responsibility for administering EPSDT.

The State Medicaid Agency is responsible for implementing the EPSDT program. However, certain parts of the program can be delegated to Health Departments.

EPSDT faces the task of bringing together medical providers and the government. Medical care in the U.S. has traditionally been the responsibility of the individual private practitioner. Consequently physicians are often unhappy with the government requirements placed on them. Government reimbursement rates for services are often lower than private practice rates. The delay in receiving government reimbursement for their services is another factor which discourages private physicians from participating in government medical programs. Private physicians are also unaccustomed to maintaining extensive systematic records required by the government. At the same time state and county governments are concerned with curtailing costs and enforcing provider eligibility standards. Friction between

physicians and the government can adversely affect the treatment phase of the program.

Because EPSDT is primarily a state administered program, each state defines and implements EPSDT according to its own resources and regulations within Federal minimum standards. States with Medicaid programs were not required to provide preventive health services before passage of the EPSDT. Many states objected to the comprehensive nature of the new required services, claiming that they did not have the financial or medical resources necessary to carry out specific areas of the program such as outreach. The expected heavy costs associated with the program delayed the implementation of EPSDT in many states.

Congress became impatient with the states' reluctance to implement the EPSDT program and added a penalty provision in 1972. The penalty reduced federal AFDC funds available to the state by one per cent per quarter if the state failed to meet minimum federal requirements. The threat of the penalty stimulated state and local agencies to implement the program in compliance with federal regulations.

The EPSDT legislation provides a federally sponsored state administered program of comprehensive health services for about 12 million Medicaid eligible children and youth from 0-21 years of age. The goal of the program is to ensure that every child eligible for Medical Assistance has the

opportunity to enter the health care system and receive periodic screening (both physical and developmental), diagnosis and treatment if needed.

The focus of the EPSDT screening program such as EPSDT differs from a routine physical check-up, since its function is to examine an individual for pre-symptomatic signs of illness before major medical problems develop. Relatively simple screening procedures can identify healthy children as well as those who have suspected medical and/or developmental problems. The comprehensive screening services provided through EPSDT include:

-physical growth assessment
-physical and developmental history
-unclothed physical assessment
-developmental assessment
-dental assessment
-hearing test
-vision test
-test for:
  anemia
  tuberculosis
  diabetes
  urinary tract infections
  sickle cell anemia
-assessment of nutritional status
-assessment of immunization status

If suspected abnormalities are found during the screening, arrangements are made for diagnosis and treatment by appropriate health professionals.

A large scale screening program for children, if followed by treatment and periodic reassessment, has the potential to provide long term health and cost benefits.

All too often health problems, particularly in the areas of hearing and vision, do not become apparent until a child is experiencing learning difficulties in school. If discovered early, further complications can often be avoided. Frequently, undetected physical or developmental problems can eventually lead to emotional problems which may be even more difficult to cure. For example, a child who has a hearing problem may begin to feel he or she is being ignored, simply because he cannot hear what is going on around him. The child's immediate feelings of rejection may result in later personality disorders.

The EPSDT program is based on the assumption that it is less expensive to prevent handicapping conditions in childhood than to provide lifelong support for a handicapped adult.

The cost benefits of a preventive health care program can be illustrated through the example of a measles immunization program. From 1953-1962, before measles immunization, an average of four million cases of measles occurred in the United States each year. Health authorities projected that this rate would continue without any immuni-

zation program. After immunization programs were initiated in 1963, the incidence of measles dropped sharply. By 1968 the estimated number of cases was down to 250,000.

Various cost factors were calculated such as lost work days, school days, hospital costs, physician services and the care of the mentally retarded (which occurred as a result of the disease). The cost savings derived from the immunization program was $531 million. The total cost of both public and private immunization programs was $108 million; the net economic benefit was $423 million. The reduction of the burden on the medical care system due to the measles irmunization program was also significant. Hospital days were decreased by 555,000 and physicians visits by 5,000. An estimated 3,244 cases of mental retardation were prevented.*

The intent of EPSDT is to aggressively and periodically review the health of all eligible children of low income families in the United States to ensure that necessary treatment is received. Outreach, case management and supportive services are required to achieve this goal. In applying these techniques, EPSDT follows and even expands

*American Public Health Association Policy Statement on Prevention, The Nation's Health, October 1975.

the traditional concepts of the public health sector. Public health nurses and maternal and child health programs have previously emphasized the importance of outreach and case management. However, these activities are not characteristic of the traditional private health care system or local health departments. Consequently, local agencies lack experience, expertise, and resources to carryout all these components of the EPSDT program.

In order to provide broad health care coverage to Medicaid eligible children the EPSDT program is attempting to bring about new relationships between public health and welfare agencies. Successful implementation of EPSDT requires working together with other organizations who share the same goal: ensuring that all eligible children have access to preventive health services and are linked to an ongoing health care system. To achieve this objective, state EPSDT programs have been encouraged to obtain assistance from other state or local agencies who are involved with health care delivery programs for children.

C. THE HEAD START - EPSDT COLLABORATION

The goals of the health services component of Head Start and of the EPSDT program focus on prevention, identification and treatment of illness, health education, and linkage of the child and family to an ongoing health care system. Both programs are concerned with bringing children of low-income families into a health delivery system which will assure ongoing access to regular care. Head Start and EPSDT serve overlapping target populations. Recognizing these common goals, the two administering agencies began discussions in 1973 about possibilities for collaboration between the two programs.

In June 1974 the Office of Child Development provided supplementary funds to 200 local Head Start demonstration programs to develop replicable approaches for collaboration with the EPSDT program. These additional funds were used by many local programs to hire a full-time EPSDT Coordinator responsible for coordinating the Head Start EPSDT effort with local health providers, health departments, and welfare agencies.

This collaboration included the provision of Head Start support services such as public information, transportation, referral and follow-up. These related support services are necessary to ensure that children receive health services. Eligible families must be provided with

information about EPSDT in order to learn about the program. Transportation may be necessary for Medicaid enrollment at the welfare agency and for getting children to medical appointments. The process of referral and follow-up ensures that health problems detected during the screening are actually treated. The provision of these health related support services comes under the direction of the Health Coordinator.

During the first year of the collaborative effort, Head Start programs assisted Head Start Medicaid-eligible children and their siblings in receiving EPSDT services. In addition, a small number of potentially eligible Head Start children were referred for Medicaid eligibility determination. Subsequently, those determined to be eligible received Medicaid cards and were assisted in receiving EPSDT services. In addition, Head Start assisted a number of non-Head Start children other than siblings up to age six, in receiving EPSDT services.

During the second year greater emphasis was placed on the outreach component of the program. For example, the social service staff responsible for Head Start outreach and recruitment for enrollment also assisted in outreach for the EPSDT program.

The primary purposes of the Head Start-EPSDT collaborative efforts are to:

1) utilize Head Start outreach capabilities to identify, inform and provide services to Medicaid-eligible children from birth to age six;
2) make maximum use of Medicaid EPSDT to pay for required health services provided to Medicaid-eligible children enrolled in local Head Start programs;
3) increase services for both Head Start and non-Head Start children, including:
   a) provision of transportation necessary to get children to medical appointments by making arrangements with volunteer church groups, service clubs, and private agencies, or by using Head Start transportation resources;
   b) exchange of case management information between Head Start and EPSDT programs to follow the child's progress through screening, diagnosis and treatment.*

The full potential of preventive health care programs for children such as Head Start and EPSDT can best be realized through the mutual efforts of both programs.

* See the OCD-MSA joint memorandum on exchange of information dated June 1, 1976 (SRS-AT-76-86).

SECTION II.

COLLABORATION WITH STATE AND LOCAL HEALTH AND WELFARE AGENCIES

What Does it Mean to Collaborate?

To collaborate is to work together. Head Start projects need to work with Medicaid EPSDT to further both programs' objectives. In order to successfully utilize EPSDT services, Head Start grantees need to work with the appropriate personnel from local health and welfare agencies to increase their understanding of the Medicaid EPSDT program and to assist Medicaid personnel to increase their knowledge of the Head Start health component.

Why Collaborate?

It is difficult for Head Start to utilize Medicaid EPSDT services without working with the other agencies that are responsible for administering the mandated components of EPSDT. These agencies often provide services necessary to help the EPSDT program meet state requirements by 1) identifying eligible children; 2) informing families about EPSDT and explaining where and how services can be obtained; 3) making arrangements to provide screening, diagnostic, and treatment services with medical professionals; 4) referring all children suspected of having a health problem for further diagnosis and treatment; and 5) providing

any necessary transportation.

The amount of rapport between Head Start programs and local health and welfare agencies can determine how well the two can work together successfully. Both Head Start and EPSDT are working toward the same goal: the improvement of children's health now and the prevention of unnecessary and costly illness in the future. It is logical for programs with this common objective to coordinate their efforts in achieving that goal.

How Does One Collaborate?

Generally, it is the Health Coordinator's responsibility to contact the health and welfare agencies. In meeting with the agencies, the Health Coordinator can: a) help to arrange a mechanism to provide adequate feedback on screening results from Health Departments and other providers: b) obtain current lists of Medicaid eligible children from the welfare department; and c) determine which agency should be responsible for support services such as health education transportation, babysitting, referral, case management, and follow-up. Ongoing collaboration can help to eliminate fragmentation and duplication of services. The following section offers examples of how several Health Coordinators have effectively collaborated with local health and welfare agencies.

What Can Head Start Programs Offer?

Head Start is a source of many services for the Head Start child and his or her family. Many members of the Head Start health staff are qualified to do some parts of health screening such as vision and hearing tests. Teachers, health aides, and parent volunteers may provide the Head Start child and his or her family with transportation to and from health appointments. They may also make home visits and help develop rapport with members of the community. These are only a few examples of the services Head Start programs can offer local health and welfare agencies when enlisting their support and cooperation.

One example involves the exchange of outreach services for information. The welfare agency, in this case, failed to provide Head Start with adequate feedback on children with suspected health problems who required follow-up. The Head Start Health Coordinator met with the Welfare agency three times to find a solution to this problem, but feedback remained inadequate. During the meetings the Health Coordinator learned that the Welfare agency's outreach activities were not very successful. Many parents and children were not showing up at the Health Department's screening and immunization clinics. Because of Head Start's familiarity with families in the community, the Health Coordinator suggested that Head Start might be able to assist the Welfare agency with their outreach activities. The Welfare agency accepted the offer. Shortly thereafter, the Health Coordinator assumed responsibility for a portion

of the outreach activity, and in turn received all the requested screening information from the Welfare agency. The Health Coordinator attributes the increased feedback to Head Start's willingness to assist the Welfare agency.

It is important to let health and welfare agencies know that Head Start wants to work with them in delivering EPSDT services. Head Start should assess its program capability, decide what it can offer the health and welfare agencies, and begin communication with these agencies.

> Collaboration is the key to the most effective use of Medicaid EPSDT. Meetings with local health and welfare agencies are essential. Sometimes they are time-consuming and frustrating, but the end product can be most desirable: Head Start working together with the local health and welfare agencies.

Meeting With the Local Welfare Agencies

One Head Start program arranged ten meetings between Head Start and the Medicaid EPSDT Division of the Department of Social Services (DSS). The purpose of the meetings was to discuss roles, responsibilities, work plans, and the available resources of both agencies in order to facilitate integration of Medicaid EPSDT with the Head Start program.

Several important issues were discussed during those sessions. The Department of Social Services described:

1) Medicaid eligibility requirements and the process of certification and recertification.

2) Transportation available to Medicaid EPSDT families.

3) Requirement for parental consent necessary to obtain medical information from the Department of Health Services or a private provider concerning the child's health background.

4) The scope of services available through the Medicaid EPSDT program.

5) The organizational structure of the Department of Social Services and the responsibilities of each division.

During the meetings the Head Start Health Coordinator proposed that the Department of Social Services provide desk space and a telephone for use by the Head Start Family Counselor (previously a health aide). The Health Coordinator felt that by locating the Family Counselor within the Department of Social Services the Head Start staff member would be more accessible to the EPSDT target area. This would also eliminate duplication of services and decrease Head Start's costs. The Health Coordinator also requested the Department of Social Services to make training available to Head Start health aides and community aides to motivate eligible families to participate in Medicaid EPSDT.

Together Head Start and the Department of Social Services discussed the following needs:

1) Development of a bilingual Medicaid booklet in

English and Spanish for Spanish-speaking Medicaid clients.

2) Development of an EPSDT brochure.

3) Development of a training program for Medicaid EPSDT workers emphasizing interpersonal skills and interviewing techniques in order to avoid stigmatizing and alienating people in need of public assistance.

4) Development of channels of communication with local providers to explain the EPSDT program and to request their cooperation in implementing the program.

5) Ways to obtain medical services where there is an insufficient number of private providers who accept Medicaid clients.

As a result of the meetings, a working relationship was established between Head Start and the welfare agency. Head Start agreed to assume responsibility for arranging and tracking screening, diagnosis, and treatment services for Head Start children enrolled in EPSDT and their siblings up to six years of age. Siblings over six were referred to the DSS/Medicaid EPSDT division.

As requested, the Department of Social Services Medicaid Division offered information and training to the Head Start Family Counselor about Medicaid, food stamps, and interviewing techniques. The Family Counselor was also provided with desk space and a telephone. Several DSS staff members participated in in-service training sessions designed for Head Start staff and parents concerning health issues and public assistance programs. The Medicaid/EPSDT

Director met personally and talked with some providers who were at first reluctant to cooperate with the program.

At the suggestion of the Head Start Health Coordinator, a representative from Mental Health Services was also invited to serve on the EPSDT Advisory Committee. In addition, Medicaid pamphlets were printed in English and Spanish.

Another outcome of the discussions was that EPSDT Advisory committees were formed in two counties which also invited the county Head Start Health Coordinators to become Board members.

Orientation Meetings for Head Start Staff and Parents

A meeting was arranged at each Head Start center by the Head Start Program Director, Health Coordinator, and DSS Family Counselor to explain the EPSDT program to the Head Start staff and parents. The Director, Coordinator, and Family Counselor answered questions and the Medicaid/ EPSDT form was distributed to the potentially eligible parents who wanted to participate in the program. An EPSDT brochure, developed by the Health Coordinator and Family Counselor, was also distributed to reinforce and clarify the information provided during the meeting.

All parents who were potentially eligible for Medicaid but who were reluctant to enroll in the program

were advised to make appointments with the DSS/EPSDT interviewer to determine eligibility. Eligible parents who were reluctant to enroll in EPSDT were visited individually and encouraged to participate.

Obtaining Parental Consent

A "parent consent" form was developed by one Health Coordinator with the approval of the Director of the Department of Health Services and Children Services. The parents sign the form to authorize the release of their children's previous medical history from clinics and private physicians to Head Start officials. The consent form eliminates the problem of confidentiality. After the parents sign the medical information release form, the Health Coordinator can go directly to the local providers' records to obtain necessary information concerning the child health history.

Provision of Screening Services

Many Head Start programs obtain screening services for Medicaid EPSDT children through local Health Departments. While it is essential that Head Start obtain these screening services, the Health Department's ability to deliver services may be limited due to insufficient manpower. The Head Start Health Coordinator can help ensure that Head Start Medicaid EPSDT children receive their screenings by offering assistance to the Health Department's screening staff.

One Head Start program has an enrollment of 960 children, the majority of whom are eligible for Medicaid EPSDT. The Health Department is the only source of EPSDT screening services for these children. The Head Start Health Coordinator pressured the Health Department to deliver screening services to Head Start Medicaid EPSDT children. However, she soon realized that Head Start was alienating the Health Department through these demands. The Health Department was also obligated to service many other Medicaid EPSDT children in addition to those enrolled in Head Start. The Health Coordinator decided a different approach was necessary if the Head Start Medicaid EPSDT children were to receive all the screening services early in the Head Start program year.

She talked personally with each of the Health Department nurses about what role she herself could play in the delivery of screening services to the Head Start Medicaid EPSDT children. The Health Coordinator was qualified to assist in many of the screenings but the Health Department requested that she participate in a two-week Public Health Nursing Session if she wished to assist in the screening. The course is mandatory for Health Department nurses.

Through the nursing session the Health Coordinator became familiar with the Health Department's screening

procedures. The Health Department nurses were impressed by the Health Coordinator's willingness to enroll in the course and recognized the sincerity of her offer to work with the Health Department. At the end of the two-week session the Head Start Health Coordinator and the Health Department nurses began working together.

The Head Start Health Coordinator picks up the necessary screening equipment from the Health Department and goes to each Head Start center. She does the hemoglobin, urinalysis, auditory, and visual testing. The Health Department nurses do the physical assessments. This arrangement works very successfully. The Head Start EPSDT children are screened early in the Head Start program year. The Health Department nurses and the Head Start Health Coordinator hope to send several Head Start Health Aides to future training sessions to enable Head Start to assume a more active role in providing screening services to Head Start Medicaid EPSDT eligible children and their siblings.

Written Agreements

One approach to establishing an effective working relationship between Head Start and state and local health and welfare agencies is to develop a written agreement which outlines responsibilities to be assumed by each agency.

A written agreement or contract can eliminate misunderstandings which may occur through oral agreements. A piece of paper alone, however, cannot ensure a successful collaboration. Any written agreement must be reinforced through frequent personal contacts to maintain the working relationship and to make any changes which may be necessary from time to time.

The following document is an example of a written agreement between a Head Start program and the State Welfare agency.

EPSDT - HEAD START COLLABORATIVE EFFORT

THE STATE WELFARE AGENCY OF THE _____ HEALTH AND SOCIAL SERVICES DEPARTMENT AND THE _____ HEAD START PROGRAM AGREE TO WORK TOGETHER ON THE LOCAL LEVEL TO PROVIDE MEDICAL SCREENING SERVICES THROUGH THE STATE'S EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM TO HEAD START CHILDREN AND THEIR SIBLINGS WHO ARE RECIPIENTS OF MEDICAID (TITLE XIX) BENEFITS.

TERMS OF THIS AGREEMENT ARE AS FOLLOWS:

1. The Head Start Program will provide the local State Welfare Agency EPSDT Coordinator with a list of Head Start children and their siblings under the age of 21 who are current Medicaid recipients. The list shall include the names of the children, the names of the parent(s), addresses and HSSD numbers.

2. The local State Welfare Agency EPSDT Coordinator will notify Head Start (1) which children have already been screened through the EPSDT Program or otherwise cannot be scheduled for screening (due to ineligibility, moves out of the county, etc.), and (2) the time, date and place of the screening clinic for the children who will be scheduled.

3. The local State Welfare Agency EPSDT Coordinator also will provide Head Start with (1) a copy of the clinic schedule form, and (2) the Medical History Cards for each child scheduled. In cases where a card has not already been completed, the EPSDT Coordinator will enter identifying information on the card and request that Head Start obtain the parent's signature and, to the extent possible, complete the medical history portion of the card.

4. The Head Start Program will make certain that the scheduled children and their parents are provided transportation to and from the screening clinic on the appointed dates and times.

5. When screening results are reviewed by the State Welfare Agency's consulting physician, copies of the results, along with the physician's recommendations for referrals for follow-up diagnosis and treatment services, will be sent to the local Head Start Program. Head Start will make every effort to make certain that the referred children obtain the recommended services through Title XIX providers, and that each provider is given an EPSDT diagnosis and treatment authorization form (which will be attached to the screening reports).

THIS AGREEMENT IS ENTERED INTO ON THIS _____ DAY OF _____ 19____.

For the State Welfare Agency: For the Head Start Program:

_____ _____

Field Office Manager Director

Orig: Local Head Start Program
cc: EPSDT Coordinator
Local County EPSDT Coordinator

Health Coordinator as a Catalyst

Medicaid EPSDT services are not yet available in some areas. In such a case the Head Start Health Coordinator can serve as a catalyst to implement a Medicaid EPSDT Program.

A Health Coordinator was working with a Head Start program in a rural area where EPSDT services were not being delivered. The Health Coordinator arranged to meet with the Medicaid Officer from the county Welfare agency to explore the problem. The Health Coordinator read the state's Medicaid EPSDT plan to prepare for the meeting. During the meeting she discovered that the state had not developed a mechanism to provide EPSDT services because the Welfare agency was not yet well-informed on the program. The Health Coordinator offered to provide in-service training for the Welfare Medicaid staff. She met weekly with the staff to discuss the goals of EPSDT, methods of effective outreach, and the importance of referral and follow-up.

The Welfare agency and the Health Coordinator formed an interagency committee composed of representatives from all programs and agencies providing services to Medicaid eligible children. Representatives from the public school systems, Catholic Charities, Head Start, and local providers developed an information exchange system designed to eliminate fragmentation and duplication of

services. The Welfare agency was designated as the central source of case management information. Any schools, agencies, and private providers delivering EPSDT services were required to present a medical information release form signed by the child's parent to the Welfare agency. The Welfare agency could then release the requested information to the appropriate agencies upon request.

Health and Welfare Agencies and Advisory Board Representation

> One way to promote collaboration between Head Start local health and welfare agencies is to solicit active representation from the agencies on the Head Start Health Advisory Committee.

Many Head Start Health Coordinators report that representatives from the local health and welfare agencies serve as active members on the Head Start Health Advisory Committee. The health and welfare agencies' participation has been invaluable to several Head Start programs. Following are reports of the experiences of these Head Start programs.

Several Health Coordinators reported that the local welfare and health departments had been reluctant to extend their services to Head Start Medicaid EPSDT children. Representatives from both departments were invited to attend meetings of the Head Start Health Advisory

Committee which addressed health budget concerns. The representatives from the local health and welfare departments were surprised to learn that the Head Start programs did not have health budgets large enough to finance all health services for all Medicaid EPSDT and non-Medicaid EPSDT eligible Head Start children. Head Start Medicaid EPSDT children were a low priority on the health and welfare department list of children needing services because the agencies had assumed that these children were covered by the Head Start budget. When this misconception was corrected, a greater effort was made on the part of both departments to work with the Head Start programs to provide Medicaid EPSDT services to eligible Head Start children.

Several other Head Start programs developed agreements with local welfare departments to obtain pertinent feedback information on EPSDT screenings necessary to maintain accurate records and current lists of Medicaid eligible families in the area. The Health Advisory Committee meetings gave representatives from the local welfare department an opportunity to work with the Head Start health staff. As a result of the meetings, Head Start Health Coordinators were recognized as competent professionals concerned with the welfare of children. The Head Start program's credibility increased and trust

developed between the welfare departments and the Head Start programs. The welfare department was willing to provide Head Start with pertinent feedback on EPSDT screening, diagnostic, and treatment services and with lists of Medicaid eligible families. At the same time the right to confidentiality was respected by only giving the information to competent professionals.

The suggestions and examples cited throughout this section indicate ways in which the Head Start programs and EPSDT can assist one another in meeting the mutual objectives of both programs.

Head Start and EPSDT programs may want to consider developing agreements or contracts outlining specific ways the programs can aid each other in providing preventive health services to all eligible children in their communities. The following example indicates the steps to be followed:

1. Child X in Head Start has no record of immunizations...
2. Head Start sends the Welfare agency a release of information form signed by the parent requesting all immunization data on Child X.
3. The Welfare agency checks Child X's record which contains a record of immunizations provided through Catholic Charities.
4. The Welfare agency sends the information to Head Start.
5. Head Start schedules any necessary immunizations for Child X.

6. The agency which administers the scheduled immunizations notifies the Welfare agency of immunizations which have been provided. (If the provider is a Title XIX vendor, the information is received by the Welfare agency through receipt of the billing form.) This arrangement has drastically cut down on duplication of services.

The Health Coordinator for this program offers some valuable advice: If EPSDT is not working in a particular county, the reason may be that the health or welfare department lacks appropriate procedures to provide these services. If this is the case, the Head Start Health Coordinator may be the logical person to provide some technical assistance.

Note: There has been recent provision of 75 percent matching monies for the employment of local EPSDT Coordinators. These persons are responsible for arranging for available resources, working with community agencies such as Head Start, assisting with referrals, working with providers in obtaining their participation etc. States are beginning to take advantage of this opportunity.

SECTION III.

COLLABORATION WITH LOCAL PROVIDERS

There are a number of resources in the community other than local health departments that can provide Medicaid EPSDT services to eligible Head Start children. This section contains a brief description of some community resources and how they are used by Health Coordinators to obtain Medicaid EPSDT services for eligible Head Start children.

Private Practitioners

Private practitioners comprise a major community resource to provide comprehensive health services to Medicaid EPSDT eligible children. They can offer a child a "medical home" which links the child into an ongoing health care system.

In many communities there is a sufficient number of private physicians and dentists who can provide services to Medicaid EPSDT eligible children. However, some physicians and dentists may be reluctant to provide preventive health care to this population. The following section contains suggestions from Health Coordinators concerning ways in which private providers may be encouraged to provide service to these children.

Translating EPSDT into Human Terms

The Health Coordinator can help physician providers to view EPSDT in human terms as a service for individual children with real health care needs, rather than as an intrusive government program.

In one community there were not enough private physicians available to provide Head Start children with diagnostic and/or treatment services. The few physicians who were available were wary of any government program, including Head Start. Any mention of Medicaid severely limited dialogue between the physician and the Health Coordinator. The Health Coordinator who encountered this obstacle met numerous times with one local pediatrician to encourage him to accept Head Start Medicaid EPSDT children. Her attempts were unsuccessful until she suggested that the pediatrician view the EPSDT program as a group of individual children with very real needs rather than as a government program. This suggestion, coupled with the Health Coordinator's persistent and earnest pleas, paid off. The pediatrician agreed to see the Head Start Medicaid EPSDT referrals. Instead of billing Medicaid, the physician offered services to the EPSDT children at no cost.

In another program, a new Health Coordinator planned to recruit physicians to provide services to Head Start Medicaid EPSDT children, but the Head Start Program Director

forewarned her that the physicians in the area were not accepting any more Medicaid clients because of the reimbursement delays. In order to overcome the physicians' reluctance to participate, the Health Coordinator decided to take a different approach. With the assistance of the Head Start Program Director, the Health Coordinator invited five pediatricians to speak with the Head Start staff on "Health Needs of Children from Low-income Families." The pediatricians accepted the invitation which included lunch with the children at the Head Start Center. Shortly after the luncheon meeting, the Health Coordinator contacted the five pediatricians to schedule appointments for EPSDT children. Three of the five pediatricians who had previously rejected any requests to accept Medicaid clients agreed to see the Head Start EPSDT children. The Health Coordinator felt that the pediatricians' personal contact with the Head Start children during the lunch was a decisive factor in obtaining the services of the doctors. The pediatricians' perceptions of the Medicaid EPSDT program were altered after they met with the children and understood their real needs. Asking the pediatricians to contribute their ideas at the meeting may also have been a factor influencing their decision to become involved with the Head Start-EPSDT children.

Reactivating Retired Health Professionals

Reactivating retired health professionals in the community can relieve problems in obtaining needed providers.

A rural Head Start program was handicapped because of a shortage of dental providers. The Head Start Health Coordinator knew of a retired dentist in the area whom she contacted about providing Head Start with dental services. In their conversation, the Health Coordinator stressed the Head Start children's need for dental services. Possible part-time work interested the dentist, but he was reluctant to locate a dental facility and to fill out Medicaid EPSDT billing terms. The Head Start Program Director and Health Coordinator offered to find a dental facility and to provide a volunteer to do the clerical work. The dentist agreed to this arrangement and applied for a vendor number. The Head Start Health Coordinator located a dental facility and through the local welfare agency, arranged to train a Head Start parent volunteer to do the billing paperwork.

The dentist is now providing all the Head Start children with dental services. Medicaid is billed for services for Medicaid eligible children; services are provided for all other children at no cost.

A Model Recruitment System

One system which was developed to enlist participation of private practitioners also provides Head Start with complete health records, ensures follow-up and eliminates duplication of services.

It was developed for a Head Start program which had 260 children, 147 of whom were Medicaid EPSDT eligibles. The program was located in a rural area without clinics or hospitals. Private practitioners were the sole source of health services. As is often the case, the private practitioners were resistant to serving any more Medicaid EPSDT eligibles because of the government billing procedure. Cooperation of the private practitioners was vital to the program if the Medicaid EPSDT Head Start children and siblings were to receive health services.

The Head Start Health Coordinator developed the following system to simplify the billing procedure in order to encourage private provider participation.

1) The Welfare Agency issues Medicaid EPSDT billing forms to the Head Start Health Coordinator.

2) The Health Coordinator then brings the billing form and the Head Start physical exam sheet to each child's appointment.

3) The doctor completes the Head Start physical exam form and signs the billing form with the understanding that the Health Coordinator will transfer the information from the Head Start physical exam sheet to the signed billing form.

4) After the information has been transferred to the signed billing form, the Health Coordinator sends one copy of the signed billing form to the state for the doctor's reimbursement. Another copy is sent to the doctor for his/her files and the third copy is retained in the Head Start files.

The Health Coordinator met with the Medicaid EPSDT Coordinator from the local Welfare Agency to propose this system. The Medicaid EPSDT Coordinator agreed to the arrangement as long as it met with the private practitioners' approval.

The Health Coordinator next presented the plan to the reluctant private practitioners. They were so enthusiastic about the new arrangement that they agreed to service both Head Start Medicaid EPSDT children and their siblings.

This system has benefited the three parties involved. Private practitioners can now be reimbursed for services provided to Medicaid EPSDT Head Start children and their siblings without complicated paperwork. The Head Start program succeeded in obtaining health services for its Medicaid EPSDT children and siblings. In addition, the program retains a copy of the bill, and therefore has a comprehensive record of screening results. Filling out the billing forms has not proved to be a tremendously time-consuming task for the Head Start program. The Welfare Agency has benefited by being able to rely on Head Start to ensure referral and fol-

low-up for Head Start children and their siblings.

When the Welfare Agency receives the billing forms, there is a notation if it came through Head Start. If the billing form does come through Head Start and if "follow-up needed" is indicated on the form, the caseworker contacts the Health Coordinator to see if any arrangements for follow-up have been initiated. The increased communication between the Welfare Agency and Head Start eliminates any duplication of services, and ensures follow-up care for Head Start Medicaid EPSDT children and their siblings.

The Head Start staff have discovered that working with the Medicaid EPSDT billing forms is not a complicated process. As a result, they are beginning to train the participating doctor's staff in filling out the forms. The expectation is that eventually the doctor's staff will become self-sufficient in handling Medicaid EPSDT billing procedures. By explaining EPSDT billing procedures to the physician's staff, the Head Start health coordinator can reinforce cooperative relationships with local providers.

Emphasizing Head Start Credibility

Health Coordinators can emphasize the credibility of the Head Start program to pediatricians to obtain their services for Head Start Medicaid EPSDT children.

Head Start is often recognized by private providers as a program seriously devoted to meeting the needs of eligible children in the community. By stressing the credibility of Head Start, one Health Coordinator was able to enlist the services of pediatricians for Head Start Medicaid EPSDT children.

The Head Start program incorporated a rural five county area which had five pediatricians. The pediatricians were one of the few resources available for referral services. The Health Coordinator found that the pediatricians were not accepting any additional Medicaid EPSDT patients for the following two reasons: 1) families often failed to show up for their appointments and 2) those families who did keep the appointment arrived with Medicaid Cards which had expired.

The Health Coordinator met with the pediatricians to explain that the Head Start program would ensure that the Head Start EPSDT children and their families would keep their appointments and present up-to-date Medicaid Cards. To convince the pediatricians of Head Start's credibility,

the Health Coordinator invited the pediatricians to visit a Head Start center to observe the program in action. The pediatricians' visit to the Head Start centers convinced them of the staff's devotion to a quality program. The Health Coordinator's assurance that appointments would be kept and that Medicaid Cards would be up-to-date and the pediatricians' own observations of the center convinced them to accept Head Start Medicaid EPSDT children.

The Health Coordinator was able to keep her commitments to the pediatricians through the following arrangements:

1. Renewal of Medicaid Cards: The Health Coordinator asks the Head Start teachers to check families' Medicaid Cards to see if they are up-to-date during home visits. If the Medicaid Cards need to be renewed, the Head Start staff assists the family with renewal procedures. Families who are reluctant to pursue the renewal often benefit from the support of a Head Start staff person accompanying them to the Social Service Agency. This system ensures that each family carries a current Medicaid Card.
2. Guaranteeing Appointments are kept: The Health Coordinator personally accompanies each child and his/her family to the appointment. Again, the support offered by the Head Start program encouraged families to show up for

appointments. In this case, if the pediatrician is rushed, the Health Coordinator is on hand to answer any questions the families may have.

Although the pediatricians refused to accept any additional non-Head Start EPSDT patients, they recognized Head Start's credibility and extended services to Head Start-EPSDT children.

Contractual Agreements with Private Providers

Some physicians and dentists will not accept Title XIX children under any conditions. If this is true in your community, the following idea may help to save your health budget. The following two letters were developed by a Health Coordinator in order to establish a contractual agreement with physicians and dentists to donate some of their services at no cost to Head Start or EPSDT.

DATE

Name
Address
City & State

Dear Dr.

COMMITMENT OF PARTICIPATING DOCTORS

Our Agency will be operating a (nine month) Head-start program for _____ children from September, 197__ to June, 197__.

Fees for office visits, treatments, and medications for children with acute and chronic illnesses will be based on customary prevailing charges in the community. Fee for physical examinations will be _____ dollars per child.

In order to carry out our program as requested by the Department of Health Education and Welfare (DHEW)/Office of Human Development (OHD), it is required that we obtain a certain amount of volunteer services. Therefore, we are asking you to volunteer your professional services on every eighth office visit. Your willingness to give us your volunteer services will be greatly appreciated.

If the above proposals are agreeable, please sign on the space provided below and return to this office. Thank you for your splendid cooperation and we are looking forward to your participation.

SIGNED: _____

DATE: _____

DATE

Name
Address
City & State

Dear Dr.

Our Agency will be operating a (nine month) Head Start program for children from September, 19__ to June, 19__.

The participation of dentists in the program is now being solicited. Within our budgetary limitations, we hope to provide the following services:*

Dental examination for each child

Restoration of decayed primary and permanent teeth as necessary

Dental prophylaxis and instruction in self-care oral hygiene procedures

Pulp therapy for primary and permanent teeth as necessary

Extraction of non-restorable teeth

Tentative plans are to send enrollees who are most in need of treatment services to the dentist first, then proceed through our roster to those who do not have as much apparent need, treating as many as our funds will allow us to do. To assist us with planning and budgeting allocation, we request a copy of the treatment plan and estimated cost

* In communities which lack adequate fluoride levels in the public water supply, application of topical flouride would be included in the list of services.

for each child, before authorizing payment for services beyond the first appointment.

In order to carry out our program as requested by the Office of Child Development (OCD), it is required that we obtain a certain amount of volunteer services. Therefore, we are asking you to volunteer your professional services on every eighth office visit. Your willingness to give us your volunteer services will be greatly appreciated. Also, please advise us if you would be willing to serve on our Health Services Advisory Committee as a consultative dental advisor.

If you are willing to cooperate, sign in the space provided below. If you do participate as a provider, we can guarantee the presence of the number of appointed children you can service on the date and time you designate.

If any additional information is needed, please contact me by letter or telephone. Thank you in advance for your cooperation in the advancement and promotion of dental health.

Sincerely yours,

Director of Health Services

mg

HSAC Dental Advisor: yes___no___

Dental Provider: yes___no___

Signature: _____ Date: _____

Neighborhood Health Centers

Many low-income areas have Neighborhood Health Centers which provide comprehensive health care. The Neighborhood Health Center relies on various sources of funding, including Medicaid. Consequently, they may be an excellent source of Medicaid EPSDT services for eligible children.

One director of a Neighborhood Health Center contacted the director of a local Head Start program and proposed a meeting. The Head Start Program Director and the Health Coordinator met on several occasions with the Director of the Neighborhood Health Center. The Director expressed an interest in having the Center service Head Start children. The Neighborhood Health Center was able to offer Head Start the following health services:

Visual screenings	Hemoglobins
Auditory screenings	Urinalysis
Physical examinations	Immunizations

The Neighborhood Health Center agreed to make these services available to Head Start Medicaid EPSDT children and siblings up to the age of six. Those Head Start children who did not qualify for Medicaid EPSDT were provided with in-kind services. In addition, the Neighborhood Center provided transportation for Head Start children and their families to and from appointments.

The Head Start Program Director and Health Coordina-

tor viewed the offer as an excellent opportunity to make services available to Medicaid EPSDT children. They accepted the Neighborhood Health Center's offer.

The Head Start Health Coordinator is responsible for scheduling appointments with the Neighborhood Health Center and for providing signed parental consent forms. A copy of the parental consent form is sent with the child to the appointment; a second copy is retained by the Head Start program. A Head Start physical examination form is filled out by the Neighborhood Health Center and returned to the Head Start Health Coordinator, along with information about necessary referral arrangements for which the center assumes responsibility. The exchange of information between the Neighborhood Health Center and Head Start enables the Health Coordinator to maintain a comprehensive record of each child's health status. The arrangement has worked very well.

If there is a Neighborhood Health Center in your area, the Head Start program may be able to use its services.

Hospitals

Hospitals may be a source of comprehensive EPSDT services for eligible Head Start children. In states where the rate and schedule of reimbursement are reasonable, the provision of EPSDT services can provide an added source of income to the hospitals and can increase their interest in servicing Head Start.

After reading a press release on Head Start's involvement with EPSDT, a local hospital administrator contacted the Head Start program. The hospital arranged a meeting with the Head Start staff. The Head Start Program Director and Health Coordinator met with the chief physicians from all hospital departments. The Head Start staff explained the nature of the health component and the necessity to use EPSDT in order to save Head Start health dollars, as well as to avoid duplication. The hospital expressed an interest in working with the Head Start program by providing screening, diagnostic, and treatment services for Medicaid EPSDT eligible children.

Five of the Head Start program's centers were located in close proximity to the hospital. This particular area had a wealth of health resources, so the Head Start program was not in desperate need of the hospital's services. However, coordinating the services of all of the agencies that provided screening, diagnosis, and treatment had been very time consuming. Also, many of the physical exam forms

the physicians returned to the Head Start Health Coordinator were incomplete.

The Head Start Program Director and Health Coordinator assessed the situation and decided to work with the hospital in developing a system which would provide comprehensive care for the Head Start Medicaid EPSDT children located in the five centers nearest the hospital. The Head Start Program Director and the hospital administrators negotiated a contract which resulted in the formation of a pediatric clinic. The hospital outpatient clinic serves as this facility. The hospital house staff provided screening, diagnostic, and treatment services for Head Start children who were referred.

The Pediatric Clinic currently operates on alternate Thursdays. Both the hospital and the Head Start staff are satisfied with the arrangement. The Head Start program has expanded its outreach effort to include 80 non-Head Start Medicaid EPSDT eligible children who are referred by Head Start to the Pediatric Clinic. The Head Start Program Director is presently considering the possibility of negotiating contracts with other hospitals to provide service to Head Start program centers.

The previous section indicates that there are a number of health care resources in the community that can provide screening, diagnostic, and treatment services to Head Start-EPSDT eligible children. Health Coordinators should not overlook local private practitioners, neighborhood health centers, community hospitals, or HMO's in their efforts to recruit health care providers for the Head Start-EPSDT program.

OUTREACH

Outreach is the process of contacting and encouraging the parents of Medicaid eligible children in the community to participate in the EPSDT program. Outreach involves educating children and their families about the value of preventive health care and the benefits of EPSDT. It also involves:

a) encouraging the family to make screening visits,

b) arranging the actual appointments, if necessary, and

c) arranging any necessary transportation and baby-sitting services.

Outreach activities are designed to notify clients of available services and to assist eligible persons in obtaining screening, diagnosis, and treatment services.

Outreach is a painstaking process which requires empathy, understanding, and patience. By personally contacting families on an individual basis, the outreach worker can explain the purpose and procedures involved in the screening process to help break down barriers which may have prevented families from using EPSDT health services.

The goal of outreach is to help guide the family to the appropriate facilities to ensure that they receive EPSDT services to which the children are entitled. Siblings and non-Head Start Children may be included in the outreach

effort in accordance with Head Start's objective of linking the entire family to an ongoing health care system. However, before extending outreach efforts to siblings and non-Head Start children, the program must determine whether its staff has the capability to assume the additional responsibility.

Why Head Start and Outreach

The local welfare agency is responsible for outreach. If EPSDT information is given during an initial interview with the welfare program, the family may be too concerned with other issues to respond. Sometimes the welfare agency inserts a leaflet on EPSDT with the check which is mailed to the family. However this method has frequently been found to be ineffective. The recipient may simply toss the leaflet aside.

Head Start may be a more effective channel for motivating families' interest in EPSDT since the Head Start staff is often better acquainted with the family as a result of previous home visits. Consequently the families may be more receptive to the Head Start staff.

This section contains suggestions and approaches on how Head Start can effectively provide outreach for EPSDT.

Personal Contact

> In order to motivate families to use Medicaid EPSDT services the families should be actively involved in a learning process. Traditional approaches to providing knowledge to families about EPSDT through mailed fliers, posters, and radio and TV announcements, are often less effective than personal contacts and individual discussions.

Effective outreach in this case is the process of providing parents with information about EPSDT and developing their interest in receiving Medicaid EPSDT services for their children. Once Head Start parents have expressed an interest in EPSDT, it is important for the Health Coordinator to meet personally with them to discuss how parents and children can benefit from participating in a preventive health program such as EPSDT. Recent findings indicate that the greatest number of screenings take place in areas where personal contacts are made. Personal contact is an ideal way to help educate the family about the benefit to be derived from EPSDT.

Parent Volunteers

Parent volunteers can be one of the most valuable resources available to the Head Start Health Coordinator.

Using parent volunteers to provide outreach services for Medicaid EPSDT proved to be highly successful in one Head Start program. The Head Start program operated in an area where the local welfare branch experienced high caseworker turnover. Consequently the welfare caseworkers were not always knowledgeable about Early and Periodic Screening, Diagnosis and Treatment. Because of this situation, the local Head Start Health Coordinator assumed much of the outreach responsibility by utilizing volunteer resources. The Health Coordinator trained Head Start parent volunteers to serve as "Parent Liaison Workers." The parents provided outreach within their own communities.

There are two major advantages to using Head Start parents for outreach services. Often the Head Start parents are also Medicaid recipients and can relate well to other Medicaid eligible parents who may be hesitant to seek EPSDT services for their children. The Head Start Parent Liaison Workers are also familiar with their communities' and neighbors' needs, and can be very effective in motivating other parents to use Early and Periodic Screening, Diagnosis, and Treatment Services.

Other Approaches to Outreach

An explanation of each procedured employed by the Medicaid EPSDT program, along with an explanation of why screening, referral and follow-up is necessary, can encourage families to take advantage of services available to them.

Booklets

One Head Start program developed an illustrated, easy-to-read booklet on EPSDT. (See sample page on following page.) The booklet uses cartoons and a dialogue story format to explain the EPSDT health care program to parents and children. The booklet can be read by children and used as a coloring book to interest children in good health. Parents can also appreciate the simplified language and lively style in which the information is presented. Information provided in the booklet was taken from recognized medical resource material and was checked by health professionals for accuracy. A brief list of facts about the government structure of EPSDT and a page of addresses and phone numbers of state welfare agencies complete the booklet. The concise creative work is a painless way of informing the entire family about EPSDT.

Another booklet developed by a Health Coordinator was designed primarily to explain EPSDT to parents. The booklet explains the process and rationale for diagnostic

HEY, THERE'S THE NEW KID THAT JUST MOVED IN NEXT DOOR.
GLEEP!
WANNA RIDE ON OUR TURTLE?
YEAH!
EPSDT
WHAT DO THOSE FUNNY LETTERS ON YOUR SHIRT MEAN?
E.P.S.D.T. MEANS EARLY AND PERIODIC SCREENING, DIAGNOSIS & TREATMENT PROGRAM.
EPSDT
SHOW-OFF I'LL FIX HIM
2

procedures such as anemia testing, sickle cell testing, urinalysis, and lead absorption screening. The importance of immunizations, dental care, and medical examinations is also stressed. The conversational tone of the booklet eliminates complex technical language and creates a personal touch. An introductory letter to parents gives the name and telephone number of the Health Coordinator and urges parents to call if they have questions about the health services provided through Head Start and EPSDT.

Health Fair

In one community a Health Fair was held for Head Start families to teach them about Medicaid EPSDT and Preventive Health. In planning the fair, the Head Start Health Coordinator was responsible for locating an appropriate facility, recruiting resource people, developing suitable games, and providing prizes.

The Health Coordinator contacted the Salvation Army and arranged to use their facilities for the Health Fair. The Health Coordinator personally contacted a pediatrician, a dentist, and a representative from the state Medicaid agency to ask them to attend the Fair and talk with the parents. In addition, the Health Coordinator arranged for volunteers from the Public Health Department to attend and screen families for hypertension and sickle cell anemia.

The Head Start nurses developed games based on a health theme. These included a matching game in which players paired symptoms with childhood diseases, and a dart game in which the player attempted to pop balloons containing facts about EPSDT and medical messages on slips of paper. The Health Coordinator contacted large wholesale houses to donate articles for prizes.

Letters announcing the Health Fair were sent home with the children. Head Start vehicles were used to trans-

port the families to and from the Fair. The morning of the Health Fair was devoted to informal discussions giving parents the opportunity to talk with the pediatrician and dentist. The state Medicaid representative discussed EPSDT emphasizing the families' rights and entitlements. After a luncheon was served, each person received $50.00 in play money to purchase tickets for the games. Any play money the participants had left or won during the games entitled them to purchase the donated gifts. Although some participants had exhausted their money, everyone received a gift.

As a result of the Health Fair, many of the participants who were eligible for Medicaid contacted Head Start about EPSDT services. Other individuals who thought they might be eligible for EPSDT services contacted the community Health and Welfare Agency.

Personal Letters

If time and staff limit the frequency of home visits, personalized letters may be effective in urging Medicaid eligible families to participate in Medicaid EPSDT.

In addition to providing outreach services for Medicaid eligible families with children enrolled in Head Start, one Health Coordinator extended outreach activities to non-Head Start Medicaid eligible families.

The Health Coordinator began with traditional outreach methods such as distributing fliers and handing out posters in the community. However these methods of outreach proved to be ineffectual; virtually no one responded.

Since there was insufficient time to meet personally with the Medicaid eligible families, the Health Coordinator decided to try the "next best" method. She obtained the names of Medicaid eligible parents and children from the Medicaid eligibility lists provided by the welfare department. The Health Coordinator sent the Medicaid eligible families handwritten two-line notes which addressed the parents and children by name (See sample note on the following page.)

Of those families who received letters, 25 per cent responded with requests for additional information and assistance in scheduling their children for appointments.

May 17, 1976

Dear Mrs. Gordon,

Have Bruce, Katrina, and Leslie had a free medical exam this year?

Please call and let me know. Thank you.

Jane Smith
Medicheck
222-1234

The Health Coordinator felt that the personal touch made the parents feel that someone had taken time to express an individual concern for their family's well-being.

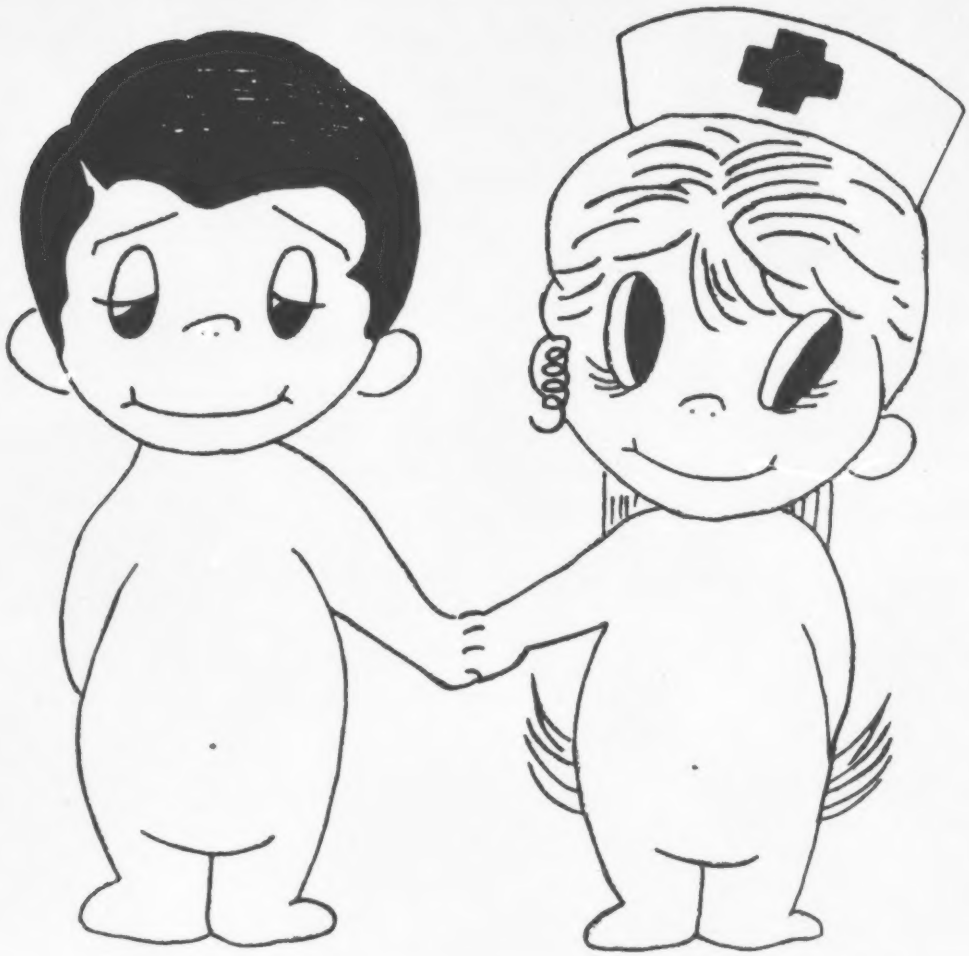
Posters

> Studies demonstrate that outreach is best conducted on a one-to-one basis. However, an eye-catching poster may inspire people to call a program for further information.

One Head Start Health Coordinator circulated this poster in laundromats, churches, and other public areas. The response was positive and the Health Coordinator assumed the responsibility of contact and follow-up for those who called.

Health, Help and Love is . . .

EPSDT Health Services



Free Medical, Dental, Transportation and Baby Sitting Service.

ASK TODAY -- YOU MAY BE ELIGIBLE!

FOR MORE INFORMATION CALL 846-1491 -- Cleveland, Mississippi

SECTION V.

TRANSPORTATION

Title XIX Medicaid agencies are mandated by the federal government to provide transportation to and from EPSDT screening, referral, and follow-up services for families who require transportation. When local health and welfare agencies responsible for EPSDT are unable to provide adequate transportation because of limited manpower or budget, it is the responsibility of the Head Start program to initiate and follow through with their own transportation for Head Start children. The following examples describe arrangements developed by Health Coordinators to transport Head Start children to and from EPSDT appointments.

Community Resources and Head Start Transportation Needs

Often community groups are eager to make a contribution to the well-being of the community's children. The Health Coordinator may want to canvass the community for possible sources of assistance in providing transportation for Head Start Medicaid EPSDT children and their families to and from appointments. The Health Coordinator should personally contact all the possible sources of assistance such as civic groups, public school systems, senior citizen groups, fraternal orders, etc. When contacting any of these groups it is

essential to explain throughly the purpose of Head Start Medicaid EPSDT, and the need for assistance with transportation.

The Health Coordinator might determine what the Head Start program can offer to other groups in return for their services. For instance, if an R.N. is on the Head Start staff, she could offer to provide First Aid training to drivers employed by private school bus companies. These companies could in turn occasionally donate their vehicles and drivers to transport Head Start Medicaid EPSDT children.

One Head Start staff contacted local churches which had their own cars. The Head Start staff talked with church administrators to explain how the churches could fulfill their Christian mission to the community by periodically loaning their vehicles to the Head Start program. This idea was accepted by the churches which were thus able to fulfill their commitment to the community by providing Head Start with transportation.

Sometimes there are resources available for transportation within the CAP agency. One Head Start program is under a CAP agency which runs a "Meals on Wheels" program. The program delivers hot meals to home-bound senior citizens. When the vehicles are not being used to deliver meals, Head Start has access to them for transporting children and their families to appointments.

A word about insurance: Before using any groups' vehicles, make certain that either the Head Start Grantee maintains adequate accident insurance or that the groups maintain liability insurance on their vehicles. It may be beneficial to obtain some professional advice on insurance coverage.

Community Resource Meetings

A community resource meeting might provide Head Start with solutions to problems such as transportation.

Lack of transportation was an enormous problem for one Head Start program which has an enrollment of 1,600 children, 500 of whom are eligible for EPSDT. The Head Start centers are scattered throughout both urban and rural areas. The solution to the transportation problem was an unexpected by-product of a county resource meeting.

The Head Start program director initiated a meeting involving special service agencies and organizations located throughout the county (e.g. health agencies, charitable organizations, education programs, etc.). The purpose of the meeting was to enable representatives from the agencies and organizations to meet one another and learn about the services offered by the various projects. During the meeting, the Head Start Health Coordinator discussed the Head Start health component, their efforts to make maximum use of Medi-

caid EPSDT, and the problems they had encountered such as inadequate transportation services. The director of a Neighborhood Day Care Center Association who was attending the discussion understood Head Start's transportation problems.

The Day Care Director later met with the Head Start Health Coordinator and the Program Director and explained that the Day Care project was reimbursed by the state for providing transportation to Medicaid EPSDT children in Day Care Centers. Families of the children were also provided with transportation to and from EPSDT appointments. The director said the Neighborhood Day Care Center Association had the capability to service the Head Start Medicaid EPSDT children. The Day Care Director requested that the Head Start program notify them a few days in advance of appointment times, locations, and of the children's names and Medicaid numbers (to enable the Neighborhood Day Care Center Association to bill the state).

This was acceptable to the Head Start Health Coordinator and the Program Director. Head Start Medicaid EPSDT children and their families are now provided with door-to-door transportation to EPSDT appointments, courtesy of the Neighborhood Day Care Association.

Community Action Agencies

Participation in Community Action Agency meetings can help Head Start staff to become more knowledgeable of other agencies' resources and similar needs.

Each of five Head Start Centers scattered across one county owned a mini-bus and had a teacher who doubled as a driver. The Health Coordinator needed to use the mini-bus all day to take children and families to and from EPSDT appointments, but the program lacked funds to hire drivers.

In the same area a senior citizen group wanted to develop a door-to-door bus service for people needing transportation to and from errands and appointments. However, the group lacked sufficient funds for mini-buses, drivers, gasoline and the "know how" to develop the system. Both the senior citizen group and the Head Start grantee are under the same Community Action Agency. During a Community Action Agency staff meeting the Senior Citizens and the Head Start program became aware of each other's need.

The senior citizen group and the Head Start program decided to pool their resources. They reached the following arrangement. The Health Coordinator would develop a central vehicle pool. The senior citizen group would apply for a grant for additional monies to purchase another mini-bus, equip them with two-way radios, and hire properly licensed

drivers. The Head Start program agreed to pay for gasoline and arranged for a central dispatcher to be hired and financed through the Concentrated Employment Training Act (CETA).

Both the Head Start Coordinator and the senior citizen group provide the transportation dispatcher with a list of addresses and appointment times. The dispatcher then coordinates the daily transportation to meet the needs of both Head Start and the senior citizen group. Although children and senior citizens are usually scheduled in different bus loads, both groups have thoroughly enjoyed the occasions when they have travelled together.

Vista Volunteers

Vista Volunteers can act as resource people to provide needed transportation and outreach services to the Head Start program.

The staff of a rural Head Start program responsible for nine centers were spending much of their time transporting children to and from health appointments. Little public transportation was available which made providing transportation difficult for Head Start and the local welfare agency (Division of Family Services). To relieve this problem the Director of the Head Start grantee applied to the Federal Action Agency for Vista Volunteers. As a result, the Head Start program received the services of six Vista Volunteers for one year.

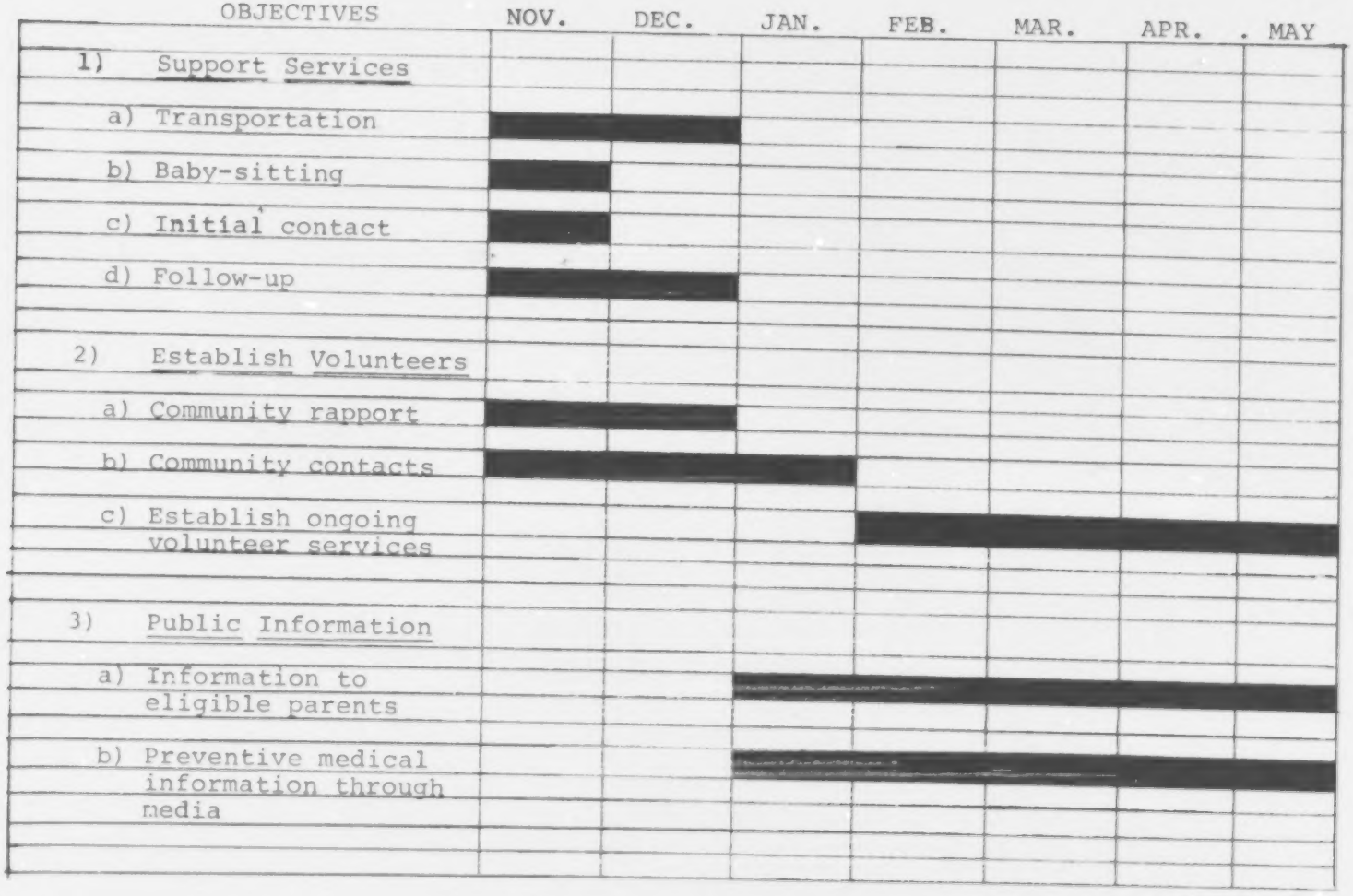
The volunteers were given in-service training by the Head Start Health Coordinator to assume responsibility for: 1) coordinating and providing transportation, outreach, and follow-up services to Head Start and the Division of Family Services; 2) serving as advocates of Head Start and preventive health; and 3) providing health education.

The Vista Volunteers made a strong impact on both the Head Start and the Division of Family Services attempts to implement EPSDT. In order to sustain the increased level of EPSDT implementation, the Head Start Health Coordinator re-

alized it would be necessary to replace the Vista Volunteers with community volunteers. The Health Coordinator and the Vista members launched a major compaign to recruit community volunteers to assume transportation and outreach activities after the Vista people left.

In order to guide the focus and level of activity before their departure, the Vista Volunteers mapped out priorities within each of the counties. The volunteers developed a planning chart which reflected their priorities each month for the remainder of the year. The chart was posted in the Division of Family Services to let the staff know which areas the Vista Volunteers would be working in each month. (An example of the chart follows.) Family Services can refer to the chart to determine when the Vista Volunteers will be phasing out their transportation services. When this occurs, families enrolled in Medicaid EPSDT will have to rely on transportation provided through community volunteers and the the Division of Family Services. The chart alerts the Division of Family Services to forthcoming client needs and allows them time to prepare for the recruitment of community volunteers.

To recruit community volunteers, the Vista Volunteers developed a Head Start newspaper designed to heighten community awareness of the needs of children from low-income families. The newspaper was circulated throughout the nine


OBJECTIVES
NOV.
DEC.
JAN.
FEB.
MAR.
APR.
MAY
1) Support Services
a) Transportation
b) Baby-sitting
c) Initial contact
d) Follow-up
2) Establish Volunteers
a) Community rapport
b) Community contacts
c) Establish ongoing volunteer services
3) Public Information
a) Information to eligible parents
b) Preventive medical information through media

county area. The Vista Volunteers also spoke to local women's clubs, fraternal orders, church groups, etc. With the assistance of the Division of Family Services, the Vista Volunteers hope to establish ongoing volunteer services for families enrolled in Medicaid EPSDT.

Ways to Obtain Transportation Reimbursement

Head Start programs can play an active role in developing a plan to meet the transportation needs of Medicaid EPSDT eligible children without using its health dollars to provide such a service.

A Head Start program operating in a rural community without pediatric services encountered difficulty in providing transportation to EPSDT children and their families. Transportation costs consumed valuable health dollars and staff time.

The Health Coordinator decided to apply to the state Medicaid agency for transportation reimbursement. A proposal was jointly developed by the Health Coordinator and the local Community Action Committee through the Department of Welfare. The proposal also included a request for reimbursement for other eligible groups needing transportation to medical appointments.

The proposal was rejected because the state was attempting to restructure its transportation system under Medicaid. However, the proposal did succeed in making the State Welfare Department aware of Head Start's and the EPSDT's community needs in structuring the revised state system. Although the Head Start program was unsuccessful in obtaining reimbursement, the spin-off from the proposal enabled the Health Coordinator to assist in planning the

revised state system. The revised transportation system was better equipped to meet Head Start's needs as well as the needs of other eligible people. Thus, Head Start can act as a resource and assume an active role in the implementation of Medicaid EPSDT at the state level.

Referral and Follow-up

Referral is the process of sending and directing the Head Start child to another agency or professional for diagnosis and treatment. Follow-up is the process of pursuing a referral to determine if the Head Start child received the necessary diagnostic or treatment services for conditions discovered during screening. Referral and follow-up are components of the ongoing process essential to ensure that the Head Start child receives all the necessary health care.

An effective system of referral and follow-up requires a high degree of parental involvement. Parents have the primary responsibility to see that their children receive the necessary follow-up. Head Start can play a major role in educating parents about the health needs of their children and how to meet them. The benefits of continuity of care need to be stressed to the family. The Health Coordinator should communicate to the child's parents that Head Start is the child's entry point into an ongoing health care system. The Coordinator should emphasize that the EPSDT program can continue to provide health care services later in the child's life when he or she is no longer eligible for Head Start services. Approaches to establishing communication between health coordinators and parents

are contained in this section.

Head Start programs also require a monitoring system to indicate whether or not the child is receiving all necessary diagnostic and treatment services. An effective system can act as a check to ensure that referral and follow-up are integrated into the Head Start/EPSDT program. The following section describes two systems which can be used for this purpose.

Follow-up Through Letters

Once a Medicaid eligible family has been contacted about EPSDT services it is important to keep them informed about their child's medical appointments and the results of any screening, diagnostic, or treatment services. The Office of Child Development emphasizes the importance of involving parents with their child's health care program.

One Health Coordinator mails letters to the child's family to help maintain close contact with Head Start parents. An initial letter informs parents of appointment dates and encourages them to accompany their child to the appointment. The letter is mailed a week before the appointment. A follow-up phone call is made the day before the appointment to help ensure that the appointment will be kept.

The first letter is designed to notify parents of

dental and physical examinations. The letter may be modified to notify parents of referral appointments. If they accompany their child to a physical examination which uncovers a possible problem requiring a referral, a health professional explains the reason for the referral. Later, a letter is sent to the parents to remind them of the appointment time. However, if the parents are unable to accompany their child to the examination, the letter notifying them of the time and place of a referral appointment is preceded by a visit from staff from the Head Start Health component or the health department. This individual provides the parents with an explanation of why a referral appointment is necessary.

If parents accompany their children to EPSDT appointments, they can be informed of the importance of preventive care. The Head Start staff explains treatment procedures and encourages the parents to schedule well-child examinations and necessary immunizations for their children. The Health Coordinator sends another follow-up letter to the parents to encourage their continued participation.

Sample Letter To Inform Parents of Appointment

_____

_____

_____

Dear Ms._____:

The _____Head Start program is assisting the _____Health Department in providing Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to eligible children. Head Start children who are eligible for Medicaid EPSDT will be receiving their health services from the Health Department. The physical examination appointment for your child _____ has been mailed to you from the _____ Health Department. If you require assistance in keeping this appointment or if you wish to make other arrangements for your child's health services, please contact us as soon as possible.

Sincerely yours,

Director of Health Services

_____Head Start

Your appointment date is Tuesday, July 8, 1976, 9:00 a.m. at the Health Department, ___(address)_____. Free transportation will be provided for you and your family if needed. Please notify _(name and phone number)___, Head Start Health Coordinator or (name and phone number) , Deputy Health Services by telephone between 8:00 a.m.-4:00 p.m., if transportation is needed.

Sincerely,

Director of Health Services

_____County Head Start

DON'T .ORGET YOUR APPOINTMENT!!!!!

GOOD HEALTH IS VERY IMPORTANT!!!!!

Follow-up Thank You Note to Parents

_____

_____

_____

Dear Ms._____:

The _____Head Start program is assisting the _____Health Department in providing Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to eligible Head Start children.

Thank you for being present with your child for his or her physical and/or dental examination and treatment on _____ at the _____Health Department.

Your cooperation is highly appreciated. Maintaining your child's health is very important, and you are the most important person in helping us achieve this effort.

Sincerely,

Director of Health Services

_____Head Start

A Referral System to Encourage Parental Involvement

The following system of referral and follow-up places a strong emphasis on parental involvement. Maintaining contact with Head Start families in one rural county was complicated due to transportation problems. However, by working with the county Health Department, the Health Coordinator was able to develop a successful system of referral and follow-up involving Head Start families.

Head Start Health Aides from each of sixteen Head Start Grantee counties schedule screening appointments with the Health Department for Head Start-EPSDT children. The Health Department nurse notifies the Head Start Health Aide if a referral is required for medical conditions uncovered during the physical assessment. Before the Head Start Health Aide schedules a conference with the child's family, the Health Aide and the Health Department nurse determine which of them will be most effective in communicating with the family. Head Start then assumes responsibility for arranging the conference and providing the family with transportation.

Both the Health Department nurse and the Head Start Health Aide use the same referral method in working with families and providers. A careful explanation of the child's health status is given to the family. The family is encouraged to participate in the selection of possible

providers. The family is then requested to sign the referral consent form used by both Head Start and the Health Department for each referral.

The Health Department nurse schedules the referral appointments. The Head Start Health Aide accompanies each child to referral appointments and brings the consent form which contains a section for the provider's recommendations. The consent form is in quadruplicate: one copy remains with the provider; one goes to the Health Department; one is retained by the Head Start Health Aide at his/her Head Start center; and the fourth is sent to the Head Start Health Coordinator.

This referral system is an excellent example of how a Head Start program and a Health Department can coordinate their activities to decrease duplication and fragmentation of services. When the Head Start Health Aide and the Health Department nurse work together, there is less chance that a child will be "lost" in the referral process.

Tickler File

Many Health Coordinators recommend the tickler file as a system to identify health problems requiring referral for diagnostic and treatment services.

A tickler file is a simplified method used to alert the Head Start Health Coordinator and staff about children who require or have referral appointments for diagnostic and/or treatment services.

The basic tickler system is a 5 x 8 index card file. Whenever a screening or physical examination indicates a child needs an appointment for diagnostic or treatment services, a referral card is filled out (an example of the card follows). A separate card is filled out for each category of appointment needed: medical, dental, and special care. When the appointment is scheduled, the date, time, and place are recorded on the card along with any support services required such as transportation and babysitting.

The cards are filed by appointment date according to the medical, dental, or special care category. Cards are placed in front of the tickler file for children who require referral services but do not yet have scheduled appointments. After each referral appointment takes place, a notation is entered on the permanent Child Health Record. If no further appointments are required the referral card is destroyed. When additional referrals are necessary,

The Referral Card

Name of Child	Type of Appointment
Name of Provider	Address of Provider
Name and Phone Number of Parent or Guardian	Name/Phone # of Caseworker

Appointment Date	Appointment Time	Action Required for Completing Referral e.g. Transportation, Baby-sitting	Notes and Recommen-dations

the card is re-filed according to the appointment date. The tickler file is usually arranged by month for the convenience of the Health Coordinator.

The tickler file is used to ensure follow-up diagnosis or treatment for all Head Start children. The referral card may be modified for Head Start children enrolled in Medicaid EPSDT to provide a system of referral and follow-up which eliminates duplication of services and to indicate the child's current Medicaid status.

Families with Head Start children enrolled in Medicaid EPSDT are often assigned a caseworker by the health or welfare agency. The caseworker is responsible for referral and follow-up. The name and phone number of a family's caseworker can be included on the card to enable the Health Coordinator to contact the agency to work with them on referrals. Whenever a referral is indicated, the Health Coordinator and the caseworker can work together to decide who will:

a) talk with the child's family to explain why the referral is necessary

b) assume responsibility for providing necessary transportation to the family

c) initiate follow-up contact if the family does not keep the referral appointment

Medicaid eligibility varies by month. Since referral appointments are often scheduled weeks in advance, the Health Coordinator can call the caseworker to find out if

the family has a current Medicaid eligibility card. The Health Coordinator can also make sure that the Head Start program has a record of the Medicaid identification number.

Once responsibilities are delegated, the Health Coordinator records them on the referral card. When both the health and/or welfare agency and the Head Start Health Coordinator are informed of each other's activities, there is little chance of duplication of services.

Wall Calendar

Some Health Coordinators flip through the tickler file and then record the names of the children and their appointment dates on a large wall calendar. One glance at the calendar in a given week enables the Health Coordinators to see which children have appointments scheduled during the following week. The Health Coordinator can then send postcards or make telephone calls to the families to remind them of their child's appointment. After each family is notified, the child's name is crossed out. Using a large wall calendar with the tickler file is an easy system for the Health Coordinator to use to remind families of their children's appointments.

SECTION VII.

Record Keeping

Every Head Start program is required to maintain a health record keeping system. Three basic types of health records are required:

- individual health records of each child enrolled in Head Start
- health services bookkeeping system which records services provided to all Head Start children and all non-Head Start children whom the Health Coordinator links to EPSDT services
- Medicaid-related documents

Even though each of the three has a unique character and use, information contained in them overlaps, and the three records are developed and used together. The bookkeeping system contains information which must be transferred to the individual child health record and to reporting documents, and is also used for scheduling appointments and providing follow-up services.

This section of the manual describes procedures and provides sample forms which can make Head Start health record-keeping easier. Both the forms and procedure may be modified in any way to meet local needs. A successful health program relies on complete, accurate, and up-to-date administrative records. Following are more detailed descriptions of the 3 Head Start record keeping systems.

The Individual Child Health Record

The most important single record is the Individual Child Health Record, which must be scrupulously maintained for each Head Start child. This record contains information to assure comprehensive medical and dental care of each child. Much of the information is gathered from parents and existing health records. The information for this record should be as complete and up-to-date as possible before the child is examined by the provider physician. The form is updated as new information about the child's health becomes available.

As screening tests are completed, results should be entered in the health record; this information is easily transferrable from an adequate bookkeeping system. Referral and follow-up care should be recorded as soon as these efforts are initiated, and the record should be updated when results are available. The record must completely, but concisely, summarize health findings as determined from the history, screening tests, and medical evaluation.

The individual child health record can be used to help the classroom teachers design an educational program especially suited to the needs of the child. The Health Coordinator should be knowledgeable about each child's health, and can give teachers and aides information to help them respond to a child with special needs. This process of

translating health findings into classroom recommendations should begin at the time the original health diagnoses are made. These recommendations should also be shared with the child's family. The Head Start Performance Standards require that parents be provided a written summary of the child's health record. The Health Coordinator can also meet with them personally to help them understand their child's special needs.

The individual child health record can be used indirectly as a tool for health education in the classroom. The series of screening examinations which all children will undergo can serve as touchstones for discussion in the classroom, as can health problems which are identified through the screening process. By discussing the causes of health problems, children can better understand the reasons for preventive health care. By describing and discussing the follow-up services that they and others will receive, children can not only proceed through diagnosis and treatment with much less anxiety, but also understand the importance of remedial care.

The individual child health record should also include classroom observations made by the Head Start teacher. Such observations can be of great value to health personnel working with the child, but care must be taken to ensure that the observations are not misused. The Health Coordina-

tor should caution the teacher to be as objective as possible when recording observations, and to be descriptive rather than judgmental in the comments.

Physicians and health workers use the individual child health record in providing needed health care. Whenever a child is referred for consultation or treatment, all of the information in the health record should be made available to the consulting or treating professional.

Confidentiality

Health records contain a large amount of information of a confidential nature. The privacy and confidence of this information must be respected. Health records should be kept in a locked file in a place that is not accessible to unauthorized persons.

Components of the Individual Child Health Record

The individual child health record contains at least the following information:

1. Child identification information
2. Emergency telephone numbers
3. Information identifying the child's physician
4. Family history
5. Personal medical history

6. Immunization record
7. Results of medical examinations
8. Referral results and recommendations
9. Teacher observations
10. Health Services Agreement Form

At the end of this section are examples of forms which may be used to record information in an individual child health record.

Coordinated Record Keeping

An important consideration for Head Start health personnel is to coordinate health records with the local school system and, if possible, the public health department. Care must be taken to insure that the selected form adheres to Head Start Performance Standards as well as meeting the requirements of other institutions. The first sample form provided at the end of this section meets these requirements for one program.

Child Health Record Form

This sample child health record form is used by a local health department, the Head Start program, and the public school system. It is the permanent cumulative health record of a child for the first 6 years of school. Prior to the child's visit to the health department, the Head Start Health Coordinator and Health Aides fill in the information on the first page of the record. The health department supplies copies of the record to the Head Start program after examining the child. The record is noteworthy because of its inclusion of nutritional and developmental status.

Georgia Department of Human Resources

INFANT AND CHILD HEALTH RECORD

Family Folder No.

Name (Last) (First) (Middle)

Child's Address (Street)

(City) (Zip Code)

PHONE NO.

Race and Sex

☐ WM, ☐ WF, ☐ NWM, ☐ NWF

Birthdate

Parent's Name

Child Lives

☐ PARENT'S HOME, ☐ ELSEWHERE

Major Care of Child By:

☐ PARENT ☐ RELATIVE, ☐ FOSTER CARE,
☐ OTHER (Specify) _____

Name of Family Physician

Child Referred By

ILLNESS OF THIS CHILD

☐ CHICKEN POX
☐ FREQUENT URI
☐ MUMPS
☐ PNEUMONIA
☐ MEASLES
☐ GERMAN MEASLES
☐ WHOOPING COUGH
☐ (OTHER) _____

Complications _____

Hospitalization _____

Handicapping Conditions _____

MATERNAL AND NEONATAL HISTORY

Mother's Prenatal Care
☐ NONE, ☐ P. H. CLINIC, ☐ OTHER

Length of Pregnancy
☐ FULLTERM, ☐ PREMATURE

Prenatal Complications
☐ NONE, ☐ TOXEMIA, ☐ HEMORRHAGE, ☐ SYPHILIS,
☐ RUBELLA, ☐ ANEMIA, ☐ OTHER _____

Delivery
☐ PHYSICIAN, ☐ MIDWIFE, ☐ OTHER _____

Delivery In
☐ HOSPITAL, ☐ HOME, ☐ OTHER _____

Type Delivery
☐ NORMAL, ☐ ABNORMAL (Explain) _____

Newborn
☐ BIRTH WEIGHT ___ LBS ___ OZS, BIRTH LENGTH ___ INCHES

Complications
☐ NONE, ☐ DIFFICULT RESUSCITATION, ☐ CONVULSIONS,
☐ CYANOSIS, ☐ INJURY, ☐ JAUNDICE ☐ OTHER _____

FAMILY HISTORY OF DISEASES

(Code Member Having Disease)

_____ ALLERGY _____ RHEUMATIC FEVER
_____ CARDIAC _____ SYPHILIS
_____ DIABETES _____ TUBERCULOSIS
_____ PSYCHIATRIC _____ (OTHER) _____

Comments _____

Age of Siblings _____

(Code: F-Father, M-Mother, S-Sibling, GP-Grandparent, O-Other)

NUTRITIONAL APPRAISAL

(Place an "X" in appropriate quare unless otherwise indicated)

1. Supplements ☐ Iron, ☐ Vitamin, ☐ Other(s), Specify _____
2. Family Uses ☐ Commodity, ☐ Stamp Program, ☐ Supplementary

BIRTH TO ONE YEAR

INTRODUCTION OF FOOD
Use "B" For Baby Food
Use "T" For Table Food

Age (Months)	Formula Stopped	Breast Feeding Stopped	Weaned From Bottle	Cereal	Fruits	Vegetables	Meat	Egg Yolk	Whole Milk
1									
2 - 3									
4 - 5									
6 - 7									
8 - 9									
10 - 12									

FORMULA

☐ Evaporated Milk
Premodified
☐ With Iron
☐ Without Iron
☐ Other, _____

If Formula change,
Specify with date:

A. If "baby cereal" (in box) was used, at what age was it stopped: _____ months.
B. Mother used "strained meat" ☐ more than, ☐ Less than meat in mixture or "dinners"

ONE YEAR AND OVER

Number of Servings Daily	Cheese & Milk	Meat & Egg	Dried Beans Peas, Peanut Butter	Cereals & Breads	Fruits & Vegetables	Sweets & Soft Drinks
None						
1						
2						
3						
4						
5 or More						

Meals Away From Home:

☐ School Lunch

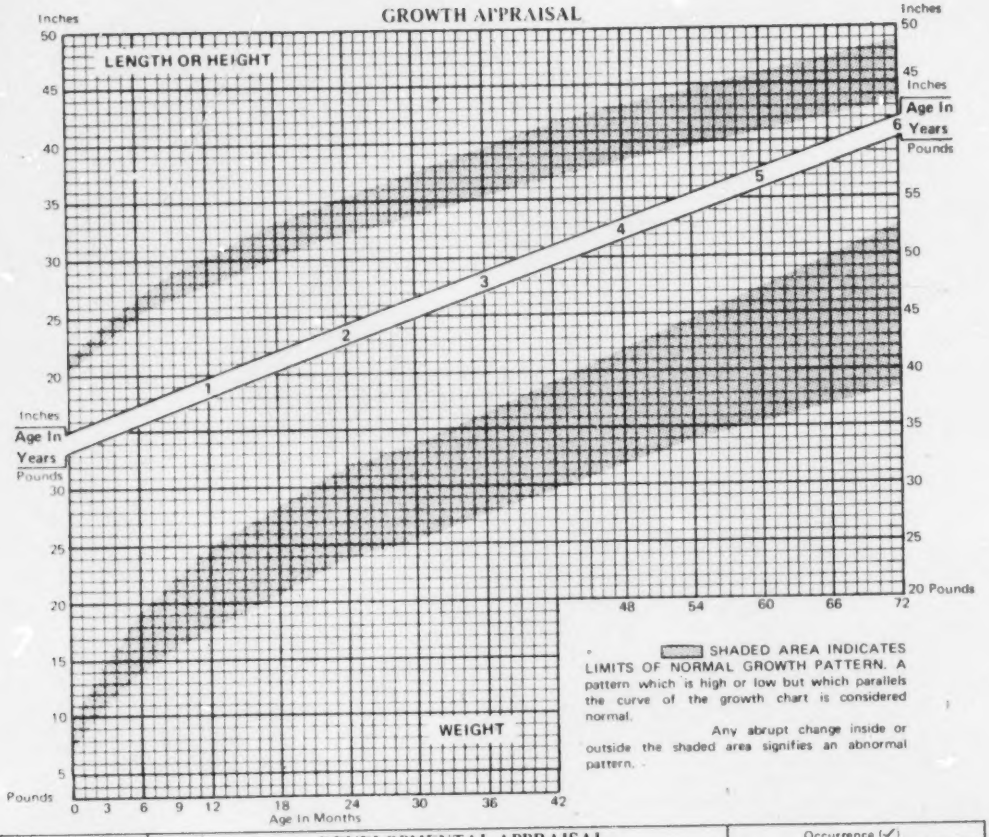
☐ Day Care

☐ Other (Specify) _____

DPH/HIS(2)—5

Page 1 of 4

(form continued on next page)


GROWTH APPRAISAL
LENGTH OR HEIGHT
WEIGHT
Inches
Pounds
Age In Months
Age In Years
1
2
3
4
5
6
SHADED AREA INDICATES LIMITS OF NORMAL GROWTH PATTERN. A pattern which is high or low but which parallels the curve of the growth chart is considered normal.
Any abrupt change inside or outside the shaded area signifies an abnormal pattern.

Usual Age of Occurence	DEVELOPMENTAL APPRAISAL Developmental Steps	Occurrence (✓) Early	Usual	Late
1 - 2 MONTHS	Head erection, slight bobbing (1-2 Months)			
	Stares and follows to midline (1-2 Months)			
	Smiles and coos on social stimulation (1-2 Months)			
3 - 6 MONTHS	Plays with hands bringing them together (3 Months)			
	Follows objects with eyes across midline (3 Months)			
	Rolls over (6 Months)			
	Turns to localize source of sound (6 Months)			
	Babbles (3-6 Months)			
7 - 12 MONTHS	Sits without support (7 Months)			
	Pulls himself to feet (10 Months)			
	Feeds himself cracker or other finger foods (10 Months)			
	Says Mama, Dada, and two other words (12 Months)			
13 - 24 MONTHS (1 YEAR OLD)	Walks without support (13-15 Months)			
	Drinks from glass held in one hand (24 Months)			
	Three word sentence with verb (24 Months)			
	Toilet trained in daytime (24 Months)			
25 - 36 MONTHS (2 YEARS OLD)	Learning to jump (25 Months)			
	Language - refers to self by pronoun me or I (25 Months)			
	Imitates vertical and circular strokes (25 Months)			
	Toilet trained daytime and nighttime (36 Months)			
37 - 60 MONTHS (3 AND 4 YEARS OLD)	Tries to draw picture, copies circles, etc. (3 Years)			
	Gives sex and name (3 Years)			
	Buttons and unbuttons, laces shoes (4 Years)			
	Skips on alternate feet (5 Years)			

Page 2 of 4

DPH/HIS(2)—5

(form continued on next page)

CHILD'S NAME

PHYSICAL APPRAISAL

MARK X FOR UNSATISFACTORY ITEMS AND COMMENT	X
(Month - Day - Year) Date	
Age Years	Months
Weight	lbs.
Height	ins.
Head	ins.
Chest	ins.
General Appearance	
Nutrition	
Skin	
Lymph Nodes	
Eyes and Vision	
Ears and Hearing	
Nose and Throat	
Teeth, Gums, Tongue, Palate	
Heart	
Lungs	
Abdomen	
Genitalia	
Skeletal System	
Neuro Muscular System	
Psychological Problems	

MARK X FOR UNSATISFACTORY ITEMS AND COMMENT	X
(Month - Day - Year) Date	
Age Years	Months
Weight	lbs.
Height	ins.
Head	ins.
Chest	ins.
General Appearance	
Nutrition	
Skin	
Lymph Nodes	
Eyes and Vision	
Ears and Hearing	
Nose and Throat	
Teeth, Gums, Tongue, Palate	
Heart	
Lungs	
Abdomen	
Genitalia	
Skeletal System	
Neuro Muscular System	
Psychological Problems	

(DATE)	CHRONOLOGICAL NOTES (For Physicians and Nurses)	(SIGNATURE)

DPH/HIS(2)—5

The Dental Health Record

The Dental Health Record gives "at-a-glance" information about a child's oral health status, treatment given and treatment indicated. The form is initiated after referral to a Dentist following a dental screening. It should be retained in the permanent child health record.

(Exempt from Budget Bureau Approval)

DENTAL HEALTH RECORD

(PRESCHOOL AND SCHOOL AGE CHILD)

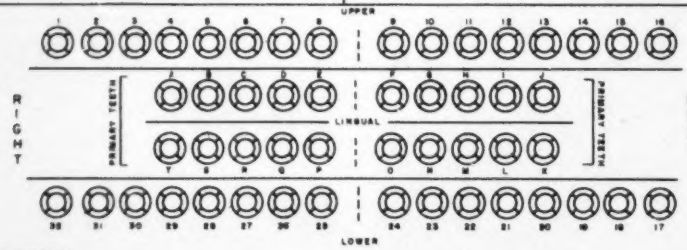
NAME OF CHILD (LAST, FIRST, MIDDLE)

IDENTIFICATION OF SCHOOL OR AGENCY

PATIENT'S ADDRESS (USE PENCIL AND KEEP CURRENT)

BIRTHPLACE | SEX

HAS THE CHILD HAD PREVIOUS DENTAL CARE? ☐ NO ☐ YES


UPPER
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
RIGHT
PRIMARY TEETH
A B C D E F G H I J
LINGUAL
T S R Q P O N M L K
PRIMARY TEETH
LEFT
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
LOWER

DIAGNOSTIC CODE

SOLID AREA INDICATES FILLING PRESENT

ZEBRA STRIPES INDICATE DECAY PRESENT

VERTICLE LINE INDICATES TO BE EXTRACTED

"X" INDICATES MISSING TOOTH

SERVICES PROVIDED: (PLEASE RECORD EACH TREATMENT ON SEPARATE LINE)

MONTH	DAY	YEAR	TOOTH #	SURFACE *	MATERIAL *	DESCRIPTION OF WORK	FEE	FOR ADMINISTRATIVE USE ONLY CODE	AGENCY
						TOTAL			

* TREATMENT CODE: SURFACES: M = MESIAL, D = DISTAL, O = OCCLUSAL, L = LINGUAL, I = INCISAL, B = BUCCAL OR LABIAL
MATERIALS: A = AMALGAM, S = SILICATE, P = ACRYLIC, C = STEEL CROWN, O = OTHER

IMPORTANT: _____ CHECK IF TREATMENT CONTINUED ON ADDITIONAL RECORD.
_____ CHECK IF ALL WORK FOR THIS CHILD HAS BEEN COMPLETED.
_____ CHECK IF TREATMENT DISCONTINUED.

REMARKS:

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

DENTIST'S SIGNATURE AND ADDRESS

DENTIST'S LICENSE NO.

CAP-HS FORM 306 APR 67

Immunization Record

This record is prepared for each child at the beginning of the program. The child's parents provide information about immunization to date, and the Public Health nurse recommends immunizations needed to complete the schedule. The required immunizations are scheduled and the appointments noted on the reverse side of the form. The forms are filed according to the month of appointment when the child's immunization program is complete. The information is recorded on the Health Control Program Sheet (p. 135).

HEAD START IMMUNIZATION RECORD

NAME AGE PARENT

IMMUNIZATION	RECORD DATE ADMINISTERED BELOW				
DPT					
POLIO					
MUMPS					
MEASLES					
RUBELLA					
OTHER					
T.B. TEST					

HEALTH DEPARTMENT

(reverse side of form on next page)

APPOINTMENTS:

DATE	IMMUNIZATION

Teacher Health Observation Card

Teachers' classroom observations of a child should be written as a separate addendum to the health record. The observations should not be transferred as part of the health record when the child leaves Head Start.

The sample Health Observation Card is designed for the teacher to record any obvious problems he or she observes in the child. The card is completed and up-dated three times during the program year by the classroom teacher. The card requires the teacher to make a yes/no response. Dates for referral and follow-up are noted at the bottom of the card.

TEACHER'S HEALTH OBSERVATION CARD

NINTH DISTRICT OPPORTUNITY, INC.

.....County

.....Program

Name ..... M ..... F ..... Date of Birth .....

Address ..... Phone .....

Parent's Name .....

Nose and Throat:														
Mouth Breathing														
Frequent Colds														
Frequent Sore Throat														
Nasal Discharge														
Frequent Nose Bleed														
Eyes:														
Sties or Crusted Lids														
Crossed Eyes														
Frowns, Strains to See														
Ears:														
Malodorous Discharge														
Earaches														
Comprehends Poorly														
General:														
Pale, Frail														
Tires Easily														
Irritable, Cross														
Attention Span Short														
Weight Problem														
Other:														
Obvious Physical Defects														

Date (month and year)														
Behavior:														
1. Does he use sickness (real or imagined) to avoid contact with people?														
2. Are his favorite activities ones which he engages in alone?														
3. Does he for long periods of time go back to a more childish manner of acting or speaking?														
4. Does he repeatedly														
—Run away from home?														
—Play hookey from school?														
—Have trouble with courts, school or other authorities?														
5. Does he show very peculiar behavior, such as														
—Twitching or other strange mannerisms which he does not seem able to control?														
—Often hurting other children without reason?														
—Destroying things so much that he has been put out of play or school group?														
—Extreme fear of anything new and always staying close to parents?														
—Complete lack of interest in anything, either people or surroundings?														
Accidents: (Specify)														

Notes on Follow-up (Results of Medical and Dental Corrections. Please Sign Notes.)

Date	Entries by Teacher and Nurse

Head Start Referral Form

Use of the Head Start Referral Form provides more complete information for the child's health record. The referring provider notes the reasons for the referral. The parents sign to authorize the appointment and release of information back to the Head Start program. The provider to whom the child is referred notes the diagnosis and recommendations on the form. One copy of the referral form is filed at the central Head Start Office and one in the Individual Child Health Record.

NINTH DISTRICT OPPORTUNITY, INC.

HEAD START REFERRAL FORM

NAME OF CHILD ..... AGE .....
ADDRESS ..... Referred To: .....
TELEPHONE .....
PARENT'S NAME .....

Type of Funds: Head Start ..... Handicap ..... Insurance Plan .....
Medicaid ..... Medicaid No. ..... Type .....
Head Start Program ..... Address: .....

Reason for Referral:

Date: ..... Signature .....

Doctor's Diagnosis and Recommendations:

Date ..... Signature .....

AUTHORIZATION FOR MEDICAL AND/OR DENTAL EXAMINATION AND FOR RELEASE OF INFORMATION

I/We hereby authorize Dr. ..... of ....., Georgia to examine .....
and release information concerning such examination to Ninth District Opportunity.

Signature of Parent Date

Please forward this report to: Mrs. Joe Hammett, RN
Ninth District Opportunity, Inc.
P. O. Drawer L
Gainesville, Georgia 30501

Health Services Agreement Form

The form is signed by the Head Start child's parents at the beginning of the program year, prior to the delivery of health services. The consent for psychological evaluation is signed only if such an evaluation is indicated. The Health Services Agreement Form includes an authorization for sharing health information between the health department and the Head Start program. It could be modified to allow exchange of information between Head Start and private providers.

NINTH DISTRICT OPPORTUNITY, INC.

HEALTH SERVICES AGREEMENT FORM

Available Health Services in the Head Start Program

A. The following health services will be available to your child this year in the Head Start Program. Please check Yes on the list below if you agree for your child to receive that health service — No if you do not wish this service.

CHILD'S NAME.....

Service	Yes	No
Diphtheria, Pertussis, Tetanus (DPT)		
Polio		
Measles		
Rubella		
Tuberculin Test		
Hematocrit or Hemoglobin		
Vision Screening		
Hearing Screening		
Dental Screening		
Physical Examination		
Dental Examination		
Dental Repair if Needed		
Speech Screening		

B. Please list any Drug Allergies your child may have.....

.....

Parent's Signature Date

STATEMENT OF RELEASE OF INFORMATION

C. I hereby authorize the Georgia Department of Human Resources and Ninth District Opportunity, Inc. to interchange health information (medical and dental records) concerning my child while he is enrolled in the Head Start/Home Start Program.

Parent's Signature Date

D. Ninth District Opportunity hereby has my consent and authorization to schedule and obtain a psychological evaluation for .....of the ..... County Head Start Program. Ninth District Opportunity will treat results of aforementioned psychological evaluation in a confidential manner; thereby utilizing such information for the furtherance of the child's individual progress and in the scope of the ..... County Head Start Program only.

Parent's Signature Date

Bookkeeping System

A well-developed Health Services Bookkeeping System assures that identified problems will receive prompt attention. It is a useful tool to help health personnel identify areas requiring follow-up procedures. For example, it can reveal an incomplete immunization record or a gap in referral and follow-up. These are essential to the effectiveness of Head Start and Title XIX (EPSDT) coordinated health efforts. Three groups of children are eligible for referral and follow-up services:

- Head Start children
- Siblings of Head Start children
- Medicaid eligible children, 0-6 years, in the community.

In using the Health Bookkeeping system. The Health Services director can be certain that:

- Previous health care is considered in planning the health program for each child.
- The health program is developed in a logical sequence.
- Gaps in health screening or treatment are noted and appropriate action can be taken.
- Each child is introduced to a medical provider who can be responsible for his future care.
- Children eligible for EPSDT services are enrolled in the program.
- Adequate data is available to assess the status and progress of the Health Program.

The documents needed for adequate bookkeeping include:

- Health Control Program Sheet
- Dental Program Control Sheet
- Medicaid Enrollment Form
- Medical/Dental Resource Record

Samples of these forms with explanation of their use are provided at the end of this section.

The Health Control Program Sheet

The Health Control Program Sheet records medical, dental, nutritional, mental health, and immunization information for all children in each center. The following code is used in filling out the sheet:

R (in red)	- problem noted, follow-up needed
OK (in blue)	- normal results
C (in green)	- follow-up completed
N/T (in pencil)	- non-testable

The health coordinator can scan the sheet and determine the status of each child's health program and make plans accordingly. Data on any non-Head Start children given EPSDT services as a result of Head Start efforts should be entered on this form.

HEALTH CONTROL PROGRAM SHEET

NAME OF HEAD START CENTER | CLASS ROOM | PROGRAM YEAR

PLACE CHILD NAME AND I.D. NUMBER BELOW

NAME OF HEAD START CHILD	Withdrawn	SCREENING												REFERRAL		TREATMENT				
		Medical History	Growth Assmt	Vision	Hearing	Speech	Hemoglobin	Tuberculin	Urinalysis	Sickle Cell	Physical Exam	Lead Poisoning		Screening Complete Date	Received Diagnostic Testing	Acute	Chronic	Surgical	Special Services	Other Treatment
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
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19																				
20																				
21																				
22																				
23																				
24																				
TOTALS																				

(form continued on next page)

ENROLLMENT	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	Person Reporting
HANDICAP										Program I.D. Number
MEDICAID										

NUTRITION		DENTAL				MENTAL HEALTH			IMMUNIZATION							
Referred for Assessment	Treatment	Initial Assessment	On Going Treatment	Date Treatment for an Acute Condition	Date That Dental is Complete	Date Referred for Psychological Testing	Receive Testing or Counseling	Date Complete	Dpt.	Polio	Mumps	Measles	Rubella	Other	Remarks

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Dental Program Control Sheet

The Dental Program Control Sheet tracks the Head Start child through his individual dental program. The source document for this composite form is the Dental Health Record kept in each child's health file. A new control sheet should be developed for different portions of the year depending on the frequency of dental screening and referral.

DENTAL PROGRAM CONTROL SHEET

HEAD START PROGRAM: _____ CLASS: _____ PROGRAM YEAR: Month___ Year__ to Month___ Year____

Child's Name	Year in Program	Screen Category	Dentist Exam	Exam Cost	EXAM NEEDS			TREATMENT							
					Fillings	Extractions	Est. Cost	SS Crowns	Pulpotomy	Extractions	Fillings	Other	Dentist	Total Treatment Cost	Completed

The Medicaid Enrollment Record

The Medicaid Enrollment Record lists the children who are eligible for Medicaid (EPSDT) services during a given month. Because Medicaid Eligibility may change, it is necessary to review status each month. One copy of the record is filed at the Head Start center and another at the Head Start central office accounting department.

NINTH DISTRICT OPPORTUNITY

MEDICAID ENROLLMENT RECORD

Month of _____ County _____

Child's Name	Birthdate	Parent's Name	Address	Medicaid No.

Medical and Dental Resource Record

The Medical and Dental Resource record lists medical and dental providers and other health resources available in the community. The record is completed during the first month of the program year. One copy is filed with the Head Start center, and a second copy is retained by the Health Coordinator at the Head Start Central Office.

MEDICAL AND DENTAL RESOURCE RECORD

COUNTY_____ NUMBER OF CENTERS_____

NUMBER OF CLASSROOMS_____ NUMBER OF STAFF_____

HEALTH DEPARTMENT ADDRESS_____

CITY_____ STATE_____ ZIP_____

HEALTH NURSE_____ PHONE_____

DENTIST (for non-medicaid)_____

ADDRESS:_____ PHONE_____

CITY_____ STATE_____ ZIP_____

DENTIST (for medicaid)_____

ADDRESS:_____ PHONE_____

CITY_____ STATE_____ ZIP_____

LOCAL DOCTOR_____ PHONE_____

ADDRESS_____ PHONE_____

FAMILY AND CHILDREN SERVICE

DIRECTOR_____ PHONE_____

ADDRESS_____

SPEECH THERAPIST_____

AUDIOLOGIST_____

MENTAL HEALTH_____

HOSPITAL_____

ADDRESS_____

_____ PHONE_____

Medicaid-related Bookkeeping

Use of EPSDT services for Head Start and non-Head Start children usually involves additional record-keeping. Some providers will send a "screening results" form back to the program after screening has been provided to the child. This should be filed in the individual child health record. If a Head Start program provides screening services, it will retain a copy of the state billing form for accounting purposes.

Many states are currently in the process of developing Medicaid reporting systems. Because of its involvement with the Medicaid EPSDT effort, Head Start will maintain records containing information needed by state Medicaid agencies. The Health Coordinator must make every effort to determine the type of reporting system used by the state, and to develop a bookkeeping system that will make possible easy transfer of the necessary information

Responsibility for Non-Head Start Children

The Health Coordinator will not be responsible for maintaining and storing individual child health records for children who are not enrolled in Head Start; those records will be maintained and kept by the providers of care. The Health Coordinator will, however, have a bookkeeping respon-

sibility for the non-Head Start children receiving EPSDT services. The bookkeeping system will make possible scheduling of EPSDT services and necessary referral and follow-up; in addition, it will make possible the reporting which will be needed to describe and evaluate the EPSDT effort at the program. Record-keeping for non-Head Start children is done on the Health Control Program Sheet (p.135).

Information Exchange and Confidentiality

It is essential to maintain the confidentiality of the child's health record while exchanging pertinent health information with other agencies. Head Start programs may have difficulty in obtaining pertinent health information from local health departments, private providers, and welfare departments about Head Start-EPSDT children who have received EPSDT services.

One way to facilitate an exchange of pertinent health information between Head Start, EPSDT providers, and health and welfare agencies is to develop a parental consent form.* The form is designed to indicate that the parent gives permission to release necessary health information about the child to the Head Start program. The Head Start Health Coordinator and representatives from the other agencies may want to design the form together so as to increase their understanding of each other's informational needs. (See sample form on following page.)

* The consent form should include the name of the person or institution to whom the record is to be released, the date when the consent form expires or a statement of how many times the record can be released, and the signature of the person allowing the information to be released.

The following parent consent form provides written permission to the health department, private practitioner, and dentist to release pertinent information to the Head Start program.

_____

_____ Head Start Program

DATE:

NAME:

ADDRESS:

I, _____, give my permission to the _____County Health Department, to Dr._____, and to Dr. _____ _____, D.D.S., to release the needed information required by __ _____Head Start program which relates to my son or daughter_____ _____.

_____ Signature of Parent/Guardian

_____ Signature of Witness

This consent form expires _____.

TITLE XIX REIMBURSEMENT TO HEAD START PROGRAMS PROVIDING EPSDT SERVICES

What Is A Reimbursed Head Start Provider?

A Reimbursed Head Start Provider is a Head Start program that receives reimbursement through Title XIX funds for the provision of EPSDT services. A Head Start program may consider becoming a reimbursed provider in the following instances:

1) If there are no providers available in the program area.

2) If available providers do not wish to participate in delivering services through the Medicaid EPSDT program.

3) If an agreement is made with health and welfare agencies to assist with support services such as outreach and transportation.

What Services are Eligible for Reimbursement?

Head Start programs may be reimbursed for the provision of Medicaid EPSDT support services and/or screening. Diagnostic and treatment services can be provided by Head Start and reimbursed when the appropriate professionals are on Head Start staff and have vendor status with the Department of Welfare.

Support Services: In some states Head Start programs may be reimbursed for costs incurred in the transportation of children and their parents to and from EPSDT

appointments. The Head Start program must complete an agreement with the state or county Medicaid agency to receive reimbursement. Transportation reimbursement is usually based on a prearranged cost per mile.

Head Start programs may also be reimbursed for outreach services. The time involved in these activities is reimbursable at a rate negotiated with the state or county Medicaid agency. Frequently, outreach and transportation are closely related so that a single contract can cover both services.

Screening Services: When providers are not available, or if all attempts to enlist the participation of local provider groups have failed, it is possible for the Head Start program to be reimbursed for the provision of EPSDT screening services. It is necessary for the Head Start program to have potential resources in both manpower and equipment before investigating the possibliity of becoming a reimbursed provider.

How Head Start Can Become A Reimbursed Provider

To become a reimbursed provider the Head Start program must first apply to the state Medicaid agency for a vendor number. This enables the Head Start program to bill Title XIX for any EPSDT screening services it provides. In some instances the Head Start grantee will be assigned a vendor

number. In some states, however, the state Medicaid agency will not grant a vendor number to Head Start grantees. In this instance, the Head Start program may enlist the support of a health professional (e.g. local pediatrician or dentist) who meets the state provider requirements. The vendor number is given to the health professional affiliated with Head Start. The Head Start program provides the EPSDT screening with all billing and reimbursement procedures being transacted under the health professional's vendor number.

The following examples are designed to provide an explanation of how several Head Start programs have become reimbursed providers. For specific information concerning your state's eligibility requirements for reimbursed providers, contact the state Medicaid agency. The Regional Health Liaison Specialist or the local medical consultant may also be able to provide Head Start programs with assistance in this area.

How Two Head Start Programs Became Reimbursed Dental Providers

PROGRAM I

Instrumental People: Head Start Program Director, Head Start Health Coordinator, Regional Dental Consultant, State EPSDT Supervisor, Local Dental Society, and the Crippled Children's Division (CCD) of the University Medical

School, CCD was aware of Head Start's provider problem. CCD offered to provide a vacant dental suite to Head Start at no cost. The Head Start program Director and the CCD Coordinator met to decide when Head Start would use the facility.

Staffing the Facility: The Head Start Program Director and the Health Coordinator arranged a meeting with the local Dental Society. The purpose of the meeting was to explain Head Start's intent to the local dentists in order to gain their approval and support for the project. The meeting was scheduled when the Regional Dental Consultant was visiting in order to request the consultant's input. The Head Start staff felt that the Regional Dental Consultant's support would be instrumental in winning the necessary approval of the Dental Society.

During the discussions some initial objections were raised concerning the program's effect on private services. The Head Start staff assured the Dental Society that any families of Head Start children who desired private dental treatment for their children would be encouraged to pursue such services. The Dental Society then approved the Head Start plan.

No formal campaign for recruitment of dentists was necessary. Recruitment was conducted primarily by "word of mouth." One dentist who had previously been involved in community health offered his services to the clinic. The

Regional Dental Consultant acted as an advocate for Head Start and provided technical assistance to the program in developing plans for the proposed dental clinic. The president of the local Dental Society recommended dentists who were willing to participate. The Head Start Program Director and Health Coordinator conducted informal interviews with the dentists in an effort to determine which were most comfortable working with children. The three dentists who were selected agreed to: 1) participate in the clinic one day a week; 2) provide their own dental assistant; and 3) receive reimbursement of $150.00 per day.

Obtaining Provider Status: The Head Start Program Director sent a letter requesting provider status to the State Department of Public Welfare along with the proposed plan. The Department of Public Welfare reviewed the proposal and sent the Head Start Program Director a contract outlining Head Start's responsibilities as a provider of Medicaid EPSDT services. The Head Start Program Director signed the contract stating that Head Start agreed to observe the rules and regulations set forth in the State Guide for EPSDT. The Head Start Program was then assigned a vendor number. The Department of Public Welfare trained Head Start volunteers and staff to fill out the Title XIX billing forms.

In the past, the Head Start staff worked closely

with the local health and welfare agencies involved with EPSDT and helped provide support services such as outreach and transportation. The State EPSDT Supervisor attended Head Start workshops and was familiar with the goals of the program. Consequently the agencies were extremely supportive of the Head Start staff and assisted them in their effort to obtain a provider status.

The Dental Clinic: The dental clinic currently operates three days a week. All the dental services required in the Office of Child Development Head Start Performance Standards are provided by the clinic and are covered under the state plan. These include:

- Dental examination
- Services required for the relief of pain or infection
- Pulp therapy for primary and permanent teeth
- Extraction of non-restorable teeth
- Dental prophylaxsis and instruction in self-care and hygiene procedures
- Application of topical flouride.

If a child requires extensive dental work, an effort is made to schedule all of his or her appointments with the same dentist to provide continuity of care.

PROGRAM II

Background: In another Head Start Dental program

the local participating dentists were accustomed to servicing both the Medicaid and non-Medicaid Head Start children. They were directly reimbursed by Head Start for all children serviced. When Head Start began utilizing EPSDT funds for dental referrals, the Health Coordinator and Program Director suggested to the Head Start Dental Director that he advise participating dentists to consider billing through Title XIX. However, the County Dental Society knew the dentists were reluctant to bill through Title XIX because of the volume of paperwork. The dental society did not want to risk alienating the participating dentists, and, therefore, did not encourage them to bill through Title XIX. Without a system for billing, the Head Start program could not be reimbursed with EPSDT funds.

How the arrangement was developed: At the request of the Health Liaison Specialist and the Regional OCD Dental Coordinator, meetings were conducted with the following persons: Head Start Health Coordinator, Head Start Program Director, Executive Director of the grantee, Head Start Dental Director, and two dental representatives from the County Health Department. The written agreement was that Head Start and the participating dentists would maintain the past billing arrangement. In order to recover EPSDT funds, the grantee would apply to the State Division of Family Services for a tax-exempt Medicaid provider number. The application

was to include the name, address, license number, and Social Security number of all dentists who were serving Head Start enrollees.

The grantee's Executive Director, Head Start Health Coordinator Program Director, and Dental Director met with the claims administrator from the State Division of Family Services to discuss the agreement. The claims administrator endorsed the agreement, and the Head Start Dental Director then applied for and received a vendor number from the Director of Family Services.

The arrangement:

1. On-Site Visits: During the first month of school, the local Head Start Dental Director (appointed by the county Dental Society) provides in-kind service by visiting each center and doing on-site screening of all children before any dental appointments are made.

2. Scheduling Appointments: After the on-site screening is completed, the Head Start Dental Director recommends and makes appointments in order of priority with participating private dental providers.

3. Billing: In the billing notice participating dentists include the service provided, a record of the teeth treated, and the fee for each individual service. The bills are sent to the Head Start Dental Director who reviews them to ensure that the fees are reasonable and customary. The bills are then sent to the Head Start Health Coordinator who checks the figures for accuracy. The Head Start program then reimburses the dentists.

How the dental program works: The Health Coordinator obtains Medicaid numbers of eligible children from the

County Division of Family Services. She then verifies their current eligibility status by obtaining transaction numbers from the Health Department. (Before Title XIX can be billed it is necessary to have the Medicaid and Transaction numbers of each child.) The Health Coordinator fills out the Title XIX request for payment forms of eligible children and sends them to the Head Start Dental Director for authorization. The Dental Director signs the forms and forwards them to the state Medicaid office for reimbursement. The reimbursement checks are returned to the Head Start Dental Director, who endorses them and turns them over to Head Start for deposit into its account. The funds are then re-programmed into the dental services budget.

The Health Coordinator feels the arrangement works well and enables the program to obtain increased dental services for those Head Start children who are not Medicaid eligible.

Example of a Head Start Program Reimbursed for Providing Medical Screening

Background: A Head Start program located in a rural area used the Health Department to deliver EPSDT services. However, the Health Department had limited resources and was unable to reach the rural areas effectively. The Head Start Program Director (who also acted as the Health Coordinator) questioned the quality of the screening provided by the Health Department. (The Health Department was eventually closed down.) The Head Start Program Director/Health Coordinator realized that the Head Start program had the potential to deliver quality screening under Title XIX.

Obtaining a Vendor Number: The Executive Director of the Head Start grantee negotiated with the Medical Assistance Unit of the State Public Welfare Division for provider status. Before signing the contractual agreement to receive a vendor number, the State Welfare Division required the Head Start program to present a plan for providing the screening services which included program supervision by a physician licensed to practice medicine in the state.

The Head Start Program Director/Health Coordinator met personally with the local welfare division to discuss the proposed plan. The plan provided for supervision by a local pediatrician who had previously done examinations and

consultation for Head Start.

The credibility and eligibility of Head Start program's plan was established primarily through written communication. A contractual agreement was signed by the Executive Director of the Head Start grantee. Shortly thereafter the Head Start grantee received a vendor number.

How the Head Start Screening Clinic Operates: The local welfare division supplies the Health Coordinator with quarterly lists of eligible children 0-6 years of age in the county. The Head Start Family Services Coordinator goes out into the county, meets with the families, explains the program, and brings the children in for the screening. The screening is conducted at facilities donated through the local fraternal orders and through the Community Services Center. A public health nurse and the current Health Coordinator, who is an audiometrist, do the height, weight, hearing, vision, blood, developmental assessment, urinalysis, and tine test. The local pediatrician examines the child. Necessary immunizations are given at the local hospital. The Head Start grantee bills under Title XIX, and the reimbursement pays the salary of the nurse and the pediatrician's fees. The Head Start Clinic screens eligible enrollees, their siblings and some non-Head Start children who are eligible for Medicaid and EPSDT.

Local Agency Resistance: Initially, the Health

Department felt threatened by Head Start's involvement with EPSDT. The Head Start Program Director/Health Coordinator met with the Health Department and stressed that Head Start did not intend to compete with the Health Department but intended to assist them by screening those children the Health Department was unable to reach.

Obtaining Provider Status: The Head Start program felt it was relatively easy to obtain provider status due to the good rapport and communication established between Head Start and the local-state welfare agencies. The State Medicaid EPSDT Supervisor had participated in numerous Head Start workshops and was familiar with the goals of the health component before the program applied for provider status.

SECTION IX.

MODEL OF A SMALL COMMUNITY HEAD START-EPSDT PROGRAM

MODEL OF A SMALL COMMUNITY HEAD START-EPSDT PROJECT: A WELL-CHILD CONFERENCE

Background

One example of a successful Head Start-EPSDT program was implemented in a small rural community which had no centralized EPSDT screening services and only limited health facilities. The five local physicians serving the area were not EPSDT contracted providers, and the small 52-bed hospital did not have a pediatric or obstetric unit. Despite such limited resources the community was able to provide screening services by initiating and implementing a well-child conference.

Planning

The idea of a well-child conference was proposed by the Community Action Council (CAC) director and became a total community project. The Head Start-EPSDT Health Coordinator organized a planning meeting and invited representatives from local health agencies to participate in the discussions. In addition to the health coordinator, the participants were: two school health nurses, the public health nurse, the hospital administrator, the hospital director of nursing, a representative from the Community Mental Health Center, the CAC director, and the regional office nursing advisor. The group discussed the location, functions, and

operational plan for the conference. Components of the comprehensive screening program and an equitable payment arrangement on a sliding fee scale for non-Medicaid participants were also discussed. The program was designed to provide screening services to any child in the community from birth to age six.

Facilities and Staffing

The well-child conference was set up in three unoccupied rooms in the community hospital. The rooms were donated for this purpose at no charge since they were not being used by the hospital. The conference setting was designed to provide a comfortable and pleasant environment. One of the rooms had originally served as a maternity ward and had a play area set up for children. Coffee was served to waiting parents. Educational booklets and pamphlets on child care and development, nutrition, and community informational resources were available. Some of the educational materials were provided free by local pharmaceutical houses. The Conference staff included: a public health nurse, the hospital administrator, the hospital nursing director, the CAC director, family day care outreach workers, volunteer community nurses, the Health Coordinator, and a Service Corporation worker who performed clerical, outreach, and transportation services. A staff physician was also hired on a

per day basis. Community volunteers were given a two-day training session by the State Department of Public Health to certify them to perform vision and hearing testing.

Outreach Efforts

Clients and volunteer workers were recruited through newspaper articles and notices. Announcements of the Conference were also sent to local physicians, dentists, optometrists, school and welfare agencies, community clubs and organizations, and the police and fire departments.

Procedures

Parents scheduled screening appointments by calling the Health Coordinator at the well-child conference. The appropriate screening tests were performed on the basis of the child's age and medical history, and according to the parent's requests and permission. Test results were sent to the child's family doctor after the parent signed a health information release form. If the child did not have a doctor and needed a physical examination, he or she was scheduled to see the conference staff physician. The staff physician would then encourage and assist the family in finding a family doctor in order to ensure continuity of care.

Evaluation

In evaluating the program, the following factors

helped contribute to the program's success:

1. The program screened a large number of children at low cost without stigmatizing children by income category. The conference services were available to all children in the community regardless of Medicaid eligibility status. The community felt that a program stressing preventive care for only Medicaid children would imply that non-Medicaid children did not need preventive health care services. Establishing a program based only on income eligibility for participation could have given the conference a "low income clinic" image. By making the services available to all children, the conference impressed upon the community the need and importance of a preventive screening program for everyone.
2. Staff costs were kept low by utilizing volunteers from the community, the hospital staff, and other existing health programs. Staff physicians from the hospital served as conference staff physician on a rotating basis at $25.00/hour.
3. Appointments were scheduled every 15 minutes and the provider was paid on an hourly basis rather than a per child basis. This eliminated unreasonable pressure on the provider to see more children in less time and also encouraged the physician to spend more time discussing procedures with the parent.

4. The child's doctor remained responsible for the child's care throughout the screening program. This prevented fragmentation of services and record keeping, and allowed greater continuity of care. The program also assisted families without a physician to obtain a regular family doctor.
5. The well-child conference was a total community effort involving the existing health facilities (hospitals and health agencies) and community volunteers.
6. Since this particular well-child conference was not designed specifically or solely for Medicaid eligible children, the letters E-P-S-D-T were not used in the conference title. Instead, the title of the project was designed to appeal to and be easily understood by the consumer population.

The well-child conference is an example of how a community with limited health resources can develop cooperation among agencies and creatively use available resources to provide appropriate screening services and preventive health education to all children in the community. The program was also successful in stimulating and encouraging parents to request and utilize screening services.

Recipe Wrap-up

The intent of Recipes for Success has been to provide examples of methods used by Head Start-EPSDT demonstration programs to provide screening, diagnosis, and treatment to Medicaid eligible children.

As indicated in the historical background portion of the manual, EPSDT is a very complex program which differs from previous Medicaid efforts. Under the EPSDT program, Medicaid not only finances medical services for eligible children, but also attempts to assure that related delivery services are available and accessible to Medicaid children. The new emphasis on the delivery of health services, record keeping, and case management requirements demand new organizational approaches. Since the effective implementation of EPSDT demands input from many different agencies and private providers, the program requires increased cooperation among groups and individuals which may influence different components of the program.

Another factor contributing to the complexity of EPSDT is that many of the children reached by the program are being introduced to the health delivery system for the first time. In addition, the program is directed towards assuring preventive health care services to these children - a concept of care which is often difficult to understand and accept.

Individual health and welfare agencies in the community often lack the manpower and facilities necessary to effectively implement EPSDT. It is therefore important for Head Start and EPSDT to develop a network of medical and supportive services in order to utilize all available resources in the community. It is hoped that this manual will assist those persons responsible for the health component of Head Start programs to determine how Head Start and EPSDT can jointly reach Medicaid eligible children through Head Start activities.

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